Service Users' Experiences of Endings from NHS Community Personality Disorder Services

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Thesis Abstract

Background: Endings are considered an important part of the therapy process, however, the empirical literature on the topic is sparse, and clinical guidelines supporting practice are limited. In particular, there is a lack of evidence derived from service users' subjective experiences that warrants further exploration.

Aim: The key aim of this research was to explore service users' experiences of endings from NHS community Personality Disorder services.

Method: Semi-structured telephone interviews were conducted with eight individuals discharged within a three-month period from one of four NHS community PD services. Interview transcripts were analysed using a deductive-inductive approach using an adapted version of Braun and Clarke's method of thematic analysis (2006). An additional 'refutational' stage was incorporated into the steps of analysis to ensure contrasting data was considered.

Results: During the analysis, it became apparent that there were two distinct over-arching themes: service users' experiences of the process of ending and their clinical reactions and responses to the ending. It was therefore decided that two journal papers would be written, each focussing on their respective parts. Three main themes relevant to the process of ending were reported in paper one; '*Service users' experiences in the context of Reflective versus Reactive practice*', '*Endings held in mind*' and '*What next*?' A further three themes emerged in relation to service users clinical experiences of endings, '*Loss*', '*Responses to loss'* and '*Boundaries*'; these are discussed in paper two.

Conclusions: In summary, service users experiences highlight the importance of taking a reflective approach to the management of endings: in particular, explicitly acknowledging the ending from the start, mentioning it throughout and 'marking' the ending of therapy were considered key features of service users' experiences. The

findings also highlighted service users' readiness to end therapy as a potential area of intervention.

The findings from the second paper emulate previous literature suggesting that endings are experienced as a loss and that endings evoke a dynamic range of emotional responses. Boundaries were also highlighted as having an important role in determining how service users' experience the loss of endings. Clinical recommendations are provided within each paper on how health professionals and services may manage endings within clinical practice. Suggestions for future research are also discussed.

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Statement of Contribution

Systematic Review	
Design, searches, quality appraisal, review of search results, analysis and write-up	Kimberley Webb (supervised by Thomas Schröder and Mark Gresswell). Thomas Schröder reviewed and edited the paper for publication.
Thesis	
Project Development	Kimberley Webb (supervised by Thomas Schröder and Mark Gresswell)
Ethics Application	Kimberley Webb
Service Recruitment	Kimberley Webb
Participant Recruitment	Participants were invited to opt into the project by contacting the research team by the service. Kimberley Webb liaised with the service managers and supported the process.
Data Collection	Kimberley Webb
Data Analysis	Kimberley Webb (supervised by Thomas Schröder and Mark Gresswell)
Write-up	Kimberley Webb (supervised by Thomas Schröder and Mark Gresswell)

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Exploring service users' first account experiences of endings from a psychological service or therapy: A systematic review and meta-ethnographic synthesis.

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Abstract

Purpose To review and synthesize the qualitative literature on service users' experiences of endings from a psychological service or therapy.

Methods A systematic search of the peer-reviewed literature was conducted. Studies were identified using specific inclusion criteria and included in the synthesis. A modified CASP tool was used to critically appraise the quality of the papers. A meta-ethnographic approach was used to synthesize the findings from the included studies.

Results Twelve papers were identified which met the inclusion criteria. The interpretation of findings suggested three key themes: anticipation of ending, service user control and sense of responsibility. Although included studies were geographically spread and the type of service varied, they were of high quality.

Conclusions The review highlights the importance of service users' perspectives in understanding the experiences of endings. The findings complement existing literature and provide new interpretations. Considerations for practice were limited however the review does provide useful directions for future research.

Practitioner Points

- Endings in therapy should consider the dyadic end of the therapeutic relationship and the emotional impact this may have upon both service users and staff.

- Further consideration should be given to how staff manage their response towards the ending.

- The time-limited structure of therapy may aid the ending process by taking responsibility away from the staff or service user.

Introduction

By definition, an 'ending' in therapy is the process whereby a service user concludes their therapy or treatment. The ending point in therapy is considered to be influenced by two distinct parties: the service user and the therapist (plus service provider if applicable).

Psychological therapy typically consists of four unique phases; assessment, formulation, intervention, and discharge. The assessment, formulation, and intervention, phases are supported in practice by theory, research and specific clinical practice guidelines and protocols (e.g., BPS; 2008, 2011). In addition, both are regularly monitored within service progress reports and evaluations (BPS, 2008). The ending phase, however, is not supported in the same way. Despite, being viewed as characteristically different from the rest of therapy (Friestein, 1974), limited attention is given to the ending phase of therapy within clinical practice.

Surprisingly, quite the opposite is true in the literature, whereby the ending phase of therapy is widely considered to be an important part of the therapeutic process (Baum, 2005; Fortune, Pearlingi & Rochelle, 1992). There is a plethora of theoretical literature considering the importance and manner in which endings are understood and managed. Early psychoanalytical perspectives (Freud, 1937) outlined how the termination of analysis should not be considered complete until the individual has processed psychological conflict and anxieties; therefore coming to a natural end. The psychoanalytical approach has a significant and growing evidence base, however; it does not meet the standards of empirically based therapy (Fonagy, 2003). Considering the time-limited structure and evidence-based approach towards therapy within the NHS, it is clear why psychoanalytical approaches to endings are incompatible with the current clinical system.

An alternative model by Quintana (1993) asserts that endings can be experienced as either a time of crisis or, as an affirming experience of growth. It describes the range of experiences which should be expected during the ending process but offers little explanation of factors influencing the two polarities. For those who experience the ending as a crisis, not only does this have risk implications but it may also render the entire therapy as ineffective. As reported by Coltart (1993) if the ending is experienced negatively, then it may compromise the whole therapy and potentially unravel therapeutic gain.

In summary, the literature offers a conceptual understanding of endings in the context of therapy. However, it is based on limited evidence, and the descriptive nature means there are limitations in the application to modern day clinical practice. The observed disconnect

between the literature on endings and how they are managed in practice may in part be explained by the lack of empirical literature on how the ending is experienced.

The 'experience' in the current context is defined as the personal encounter of the ending process. A true account of the experience would, therefore, be best told by the service users' who lived the experience; this is referred to as the first account experience within this review. Consistent with the 'ask the client' movement, research investigating service users' perspectives is said to be an empowering tool for exploring experiences in psychotherapy (Elliott, 2010). Likewise, Kazin (1999) outlined the importance of including service users' perspectives when appraising therapy.

Within the empirical literature, there are several limitations which may prevent a clear understanding of how endings are experienced from the service users' perspectives in therapy. The majority of studies that have investigated ending experiences used quantitative survey-based designs to report reasons for and reactions to the ending of therapy (Roe, 2007; Westmacott & Hunsley, 2010). The questionnaire design typically used within such studies limits the exploration and understanding of service users' ending experiences to pre-determined categories set by the authors. Ideally, experiential phenomena such as endings would be measured using qualitative methods as this would facilitate depth of understanding and allow the service user to voice their own opinions, beliefs, and accounts (Evans, 2002).

Qualitative studies exploring ending experiences have largely investigated health professionals' perspectives of the service users' experiences (Fortune et al., 1992; Lanyado, 1999). Although such studies offer valuable insights, they are the therapists' interpretation and not the service users' own account. As demonstrated by Råbu, Binder and Haavind (2013), therapists and service users often have different views of the ending experience. Therefore, the second account perspectives offered by therapists may not be an entirely reliable reflection of the ending experience.

In summary, the theoretical literature provides an understanding and outlines the importance of endings in the context of therapy. However, the literature on ending experiences consists primarily of quantitative studies and second account perspectives and therefore lacks the true account as told by service users.

Individual qualitative studies are useful in understanding service users' experiences of ending, however, they are often context dependent and therefore lack the ability to inform clinical practice (Silverman, 1998). A meta-synthesis would be one method of addressing the issue as it would enable the qualitative literature to be evaluated in a larger interpretive context. Campbell et al. (2003) described how a qualitative synthesis goes beyond the

descriptive account often seen in narrative reviews and instead uses interpretations to inform new concepts and theoretical insights.

The most common method of qualitative synthesis is meta-ethnography (Noblit & Hare, 1988). A key component of meta-ethnography involves a process of translating studies into one another. Noblit and Hare (1988) claim this preserves the distinct characteristics of the individual studies whilst offering an interpretive account. The synthesis of qualitative studies has however been debated (Atkins et al., 2008). Key issues regarding the epistemological assumptions underlying studies within the interpretivist paradigm have raised questions about whether or not, and how studies should be synthesized. However, as explained by Noblit and Hare (1988) meta-ethnography is only as interpretative as any other ethnographic account.

Aim

To explore service users' first account experiences of endings from a psychological service or therapy, a review, and meta-ethnographic synthesis were conducted. The review aimed to systematically select and appraise peer-reviewed articles that explored service users' subjective experiences of endings from a psychological service or therapy. Secondly, the review aimed to synthesize the findings and provide an interpretative synthesis of service users' experiences of endings. It was intended that the synthesis would provide a clearer understanding of service users' experiences of endings, which may inform the direction of future research and potential clinical practice guidelines.

Methods

The systematic review process followed the process described by Boland, Cherry, and Dickinson (2014). The review consisted of three main phases; a systematic review of the peer-reviewed literature, a quality appraisal of articles that met the inclusion criteria, and a synthesis of findings using a meta-ethnographic approach (Noblit & Hare, 1988).

Searches

A systematic search was conducted in March 2018 using six electronic databases: PsycINFO (1806-present), PsycARTICLES (1894-present), MEDLINE (1946-present), EMBASE (1980-2016), Web of Science (1900-2016) and Applied Social Science Abstract Index (ASSAI 1987-present). The above databases were selected because collectively they covered a range of subjects relevant to the review topic and, have previously been used in qualitative psychotherapy related reviews (e.g., Roos & Werbart, 2013). Free text searches of

relevant references and Google Scholar were also conducted to ensure all eligible papers had been sourced. Reference lists of identified papers were also checked.

Search Terms

An iterative scoping search of target databases was conducted to identify relevant key search terms. Terms were identified using free-text searches and were included if they related to the aims of the review. Alternative database search operators and terms used to catalog similar papers were also included. Relevant key search terms centred around the following four main headings, 'endings'; 'therapy'; 'experiences' and 'service users' as outlined in appendix A.

Different strategies were used to increase the effectiveness of the search (Evans, 2002) and to narrow down the search results. For example, positional operators such as ADJ and Boolean operators such as OR and AND were used to collate similar records or combine key search terms.

The current search strategy did not include a filter for qualitative studies for the following reasons. Firstly, Hughes, Closs and Clarke (2009) reported that electronic databases are insufficient in providing adequate indexing for qualitative research. Secondly, an initial scoping search demonstrated that some qualitative findings were embedded within mixed-methods designs. Therefore to ensure all qualitative data was included in the search, methodologically related search terms were not included.

Inclusion Criteria

To ensure the review was comprehensive but specific to the review aims, articles were included in the synthesis if they met the following inclusion criteria:

- Were published in a peer-reviewed journal. This ensured some level of quality control and defined the limits of the review. Policy documents, dissertations and grey literature were excluded on this basis.
- Explored experiences of endings from the service users' perspective, this criterion was central to the aim of the review.
- Endings were from a mental health service or psychological therapy. This criterion was set because the inclusion of endings from physical health services was beyond the scope and aims of the review.

- Utilized qualitative data collection and analysis. Qualitative data were also extracted from mixed-methods articles. The qualitative criterion was decided because it ensured the data included actual or interpretations of first order constructs. This concerns the meaning of the actual lived experiences of an event and is central to answering the review question.
- Written in English, however, the search was not limited to a specific country. A broader geographic range was deemed to enable a variety of cross-cultural perspectives to be captured within the review.
- Related to adults, aged 18 years or over.

Selection

Articles were selected according to the framework set out by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement (Moher, Liberati, Tetzlaff, Altman & The PRISMA Group, 2009). Duplicates were removed before the title, and abstract of relevant papers were assessed against the inclusion criteria by the author.

A total of 2075 articles were produced from the database searches. One additional article was identified through alternate search methods. Once duplicates were removed (N=601), article titles were screened. The majority of articles were excluded at this point (N=1420) as they did not meet one or more of the inclusion criteria. Abstracts of the remaining 65 articles were obtained and reviewed, of which 53 were excluded for reasons listed in figure 1. Twelve full-text articles were reviewed and found to meet the inclusion criteria and therefore were eligible for inclusion in the review.

Figure 1.

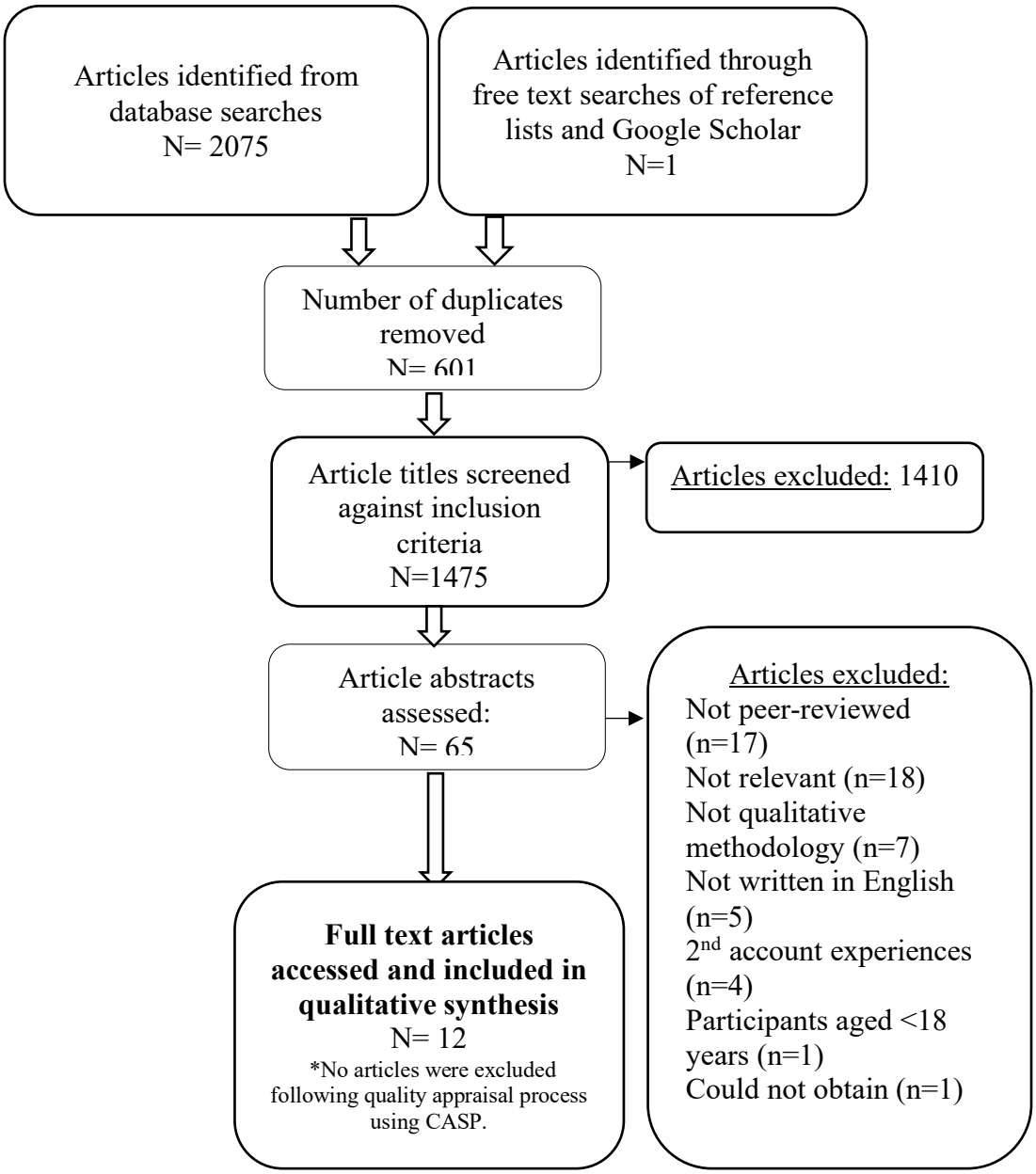

Figure 1. Process of data selection and exclusion (Moher et al., 2009)

Quality Appraisal

The quality appraisal of qualitative studies has been much debated, and there is little agreement on whether, and how a paper should be appraised (Atkins et al., 2008). The debate around whether qualitative studies should be appraised is based on a philosophical argument that the evaluation criteria used should be consistent with the approach that underpins the

research design (Fossey, Harvey, McDermott & Davidson, 2002). The majority of existing quality appraisal tools utilize a checklist style proforma, upon which studies can be evaluated against a set criteria. The approach adopts a scoring system similar to its quantitative equivalent (CASP, Public Health Resource Unit, 2013a), and consequently does not pick up on missed out on the face validity of a study (Atkins et al., 2008).

Previously, the checklist method approach to quality assessment has been criticized for appraising the quality of the written source rather than the procedure (Atkins et al., 2008; Sandelowski & Barroso, 2002). However, the written quality of a paper must meet certain standards in order for it to be replicable, for ethical assurance and to ensure enough information is provided for it to be synthesized within a review. Therefore, despite the discussed limitations, the current review will assess the quality of studies.

The Critical Appraisal Skills Programme (CASP; Public Health Resource Unit, 2013b) is one of the most documented tools used to rate the quality of qualitative studies. However, a study by Dixon-Woods et al. (2007) highlighted several limitations of the CASP (2013b), criticizing the tool on the basis that it lacked focus on the impact of findings. Given the relevance of endings to clinical practice, it is important that any quality assessment of the literature provides sufficient evidence regarding quality. Therefore in common with previous studies (Campbell et al., 2003, 2011), and advocated in a review by Spencer, Ritchie, Lewis & Dillon (2003), an adapted version of the CASP (2013b) was used to critically appraise the quality of the twelve included papers. The framework was adapted to include criteria which fit with the purpose of the review. Additional criteria further evaluated the method and analysis and therefore enabled a broader review of the evidence in comparison to the original CASP (2013b). The framework outlines fourteen criteria upon which each of the twelve review papers was appraised. A scoring system defined by Bailie and Tickle (2015) was applied as follows; two if definitely met, one for unclear and zero if not met. Studies were independently ranked by the first and second author, and a mean score was calculated. All twelve papers reviewed obtained a score ranging between 16-27 and therefore met the author's pre-defined minimum standard for sufficient quality (>14) and were included in the synthesis.

The results from the quality appraisal suggest that despite representing a wide geographical spread, the overall quality of the studies was high. The twelve papers met 89% of the quality criteria. Four studies were identified from the UK with two specific to high secure hospital settings. Given the wide geographical spread of the review studies and the

specificity of the included UK studies, contextual factors were considered when discussing the findings of the review.

Results

The findings from twelve studies were included in the synthesis. The studies included a total of 348 participants ranging from 22 to 70 years of age, from various countries; USA, UK, Israel, Argentina, and Norway. 69% were female and 31% male. Only three studies reported data on ethnicity. Nine studies collected data via semi-structured interviews; two collected written responses via open-ended questions as part of a larger mixed-method design, and one used an online qualitative survey. Data were analyzed using a variety of qualitative approaches. Whilst all studies included service users' first account experiences of endings, the research questions, and aims varied. The search strategy did not specify service or therapy characteristics, and therefore the studies included experiences of ending from both individual psychotherapy (N=9) and service transitions (N=3). Available data from studies exploring individual therapy endings indicated that therapy was predominantly delivered by therapists from a psychoanalytical orientation (N=197). Other approaches included integrative (N=30), systemic (N=13), humanistic (N=13), psychodynamic (N=10), cognitive (N=5), interpersonal (N=1), client-centered (N=4) and unspecific (N=15). Two of the studies which looked at transitions were from a UK high secure hospital. Key study characteristics are summarized in table 1.

Table 1

Characteristics of Studies

No	First Author, country, year	CASP score	Age(yrs), Gender(F/M), Ethnicity	Sample and Context	Method of data collection and analysis	Research Aims
1	Madders, UK, 2014	27	1F/8M	9 patients transitioning from high secure hospital	Semi-structured interviews, thematic analysis	To explore factors influencing discharge preparation from the perspectives of patients.
2	Tetley, UK, 2011	26	16M	16 patients transitioning from a high secure hospital	Semi-structured interviews, thematic analysis.	To explore the experiences of personality-disordered patients during the transition process.
3	Knox, USA, 2011	25	23-60yrs, 11F/1M, White/American European	12 clients terminated from individual outpatient psychotherapy	Semi-structured interviews, Consensual Qualitative Research(CQR) analysis	How do clients experience therapy termination? How does termination unfold? How does termination affect clients and the therapy process?
4	Råbu, Norway, 2013	23	25-52 yrs,10F/2M	12 former psychotherapy clients	Sessions recordings and interviews, thematic & narrative analysis	How is decision to end treatment negotiated? How do the two parties experience the process of ending?
5	Olivera, Argentina, 2013	23	22-54 yrs, 11F/6M	17 former psychotherapy clients	Semi-structured interviews, Consensual Qualitative Research (CQR) analysis	Investigate former clients' perception of change, reasons for consultation, therapeutic relationship and termination.
6	Råbu, Norway, 2013	23	25-62yrs, 24F/13M	37 former psychotherapy clients	Interviews, thematic analysis	How do clients consider their own and therapists contributions in the last phase of therapy?
7	Cuddeback, USA, 2013	22	44 yrs(Mean), 5F/6M, 6 Caucasian, 5 African America.	11 clients transitioned from assertive community team (ACT) to case management	Semi-structured interview, content analysis	To examine the experiences of consumers who were transitioned from ACT to less intensive services.
8	Etherington, UK, 2011	22	3F, 31- 45 yrs	3 ex-counselling clients	Interviews, narrative case study approach	To show clients lived experiences of reviews and endings.
9	Roe, Israel, 2006a	16	20-30 yrs(36%), 30-40 yrs (54%),+40 yrs (10%) 66F/18M	84 former psychodynamic psychotherapy clients	Open-ended questions, inductive coding analysis	To explore clients' feelings during termination of psychotherapy.
10	Bonsmann, UK, 2017	20	18-30yrs(7%),31-50yrs (73%)51-70yrs (20%), 35F/15M	50 former clients from varying therapeutic models	Qualitative online survey, thematic analysis	To understand clients experiences' of premature termination to provide insights for practitioners and services to reduce its occurance.

11	Scamardo, USA, 2004	19	23-45 yrs, 7F/2M, 3 African American,3 Hispanic and White, 3 Non-Hispanic	9 former individual therapy clients	Semi-structured telephone interviews, inductive coding	How clients determine the length of therapy, decide when to discontinue therapy and change expectations of therapy.
12	Roe, Israel, 2006b	16	20-30 yrs (36%), 30-40 yrs (54%),+40 yrs (10%),66F/22M	88 former psychodynamic psychotherapy clients	Open-ended questions, inductive coding analysis	Investigate clients' perception of the reasons for psychotherapy termination and how these related to demographics, treatment variables and satisfaction with therapy.

Table 1

Data Abstraction

Meta-ethnography is an interpretive approach to qualitative data synthesis which goes beyond the description of the individual studies to provide third-level interpretations that are considered more in-depth than numerical or narrative synthesis methods (Campbell et al., 2011). The approach provides a new interpretation which may contribute to theory development, research questions or practice implications within the field (Noblit & Hare, 1988). As discussed, there is little empirical evidence focussing on service users' perspectives, and therefore a meta-ethnographical approach would provide a synthesis of the available evidence.

Campbell et al. (2003) proposed that an example paper identified by experts may be of higher relevance and therefore argues it should be used as starting point for review. No such study was identified in the current topic field, and therefore the order was defined by the adapted CASP (2013b) quality assessment tool. Each paper was hierarchically ordered by the first and second author independently, the rankings were reviewed, discrepancies discussed, and a consensus reached. Studies were subsequently reviewed in rank order. Adaptations to the CASP (2013b) meant the relevance of the studies was factored into the quality appraisal. The authors acknowledge that the order in which studies were reviewed may have influenced interpretations and the resulting synthesis. The process, however, facilitates replication and allows higher quality papers to be reviewed first.

The seven-phase meta-ethnographic approach defined by Noblit and Hare (1988) informed the synthesis process. Each of the studies were read and re-read until familiarity with the content and detail of the studies was reached. Data was systematically extracted using a bespoke extraction template. The extract of themes utilized Schutz's (1973) notion of first, second and third order constructs. First order constructs focus solely on service users' perspectives and experiences; second order constructs are the authors' interpretations, and third order constructs are the synthesizers interpretations. The extraction of themes and third level interpretations were completed initially by the first author, they were then critically reviewed by the second and third author; disagreements were resolved by discussion.

Noblit and Hare (1988), suggested that a list of themes are used to determine how studies relate, however, they do not stipulate how the process is conducted. The synthesis was therefore guided by methods used in previous reviews (Atkins et al., 2008). Themes were extracted and listed by the first author into tables to display the key themes and concepts across all studies. Determining how themes related to one another was completed through a

gradual process of comparing, collating and collapsing themes into common categories. Themes and concepts from the highest ranking paper (paper one) were compared with paper two, synthesized and them compared with paper three and so forth. Comparisons and relationships between the themes were discussed with the second and third author in reference to the original text. These were mapped out and used to identify key relationships and an overarching model, or 'line of argument synthesis' which represented an understanding of more than the individual parts.

Three forms of meta-ethnographic synthesis were utilized within the current review to synthesize the findings of the included studies. The three methods outlined by Noblit and Hare (1988) include:

1. Reciprocal translation: similarities across the studies were identified and synthesized into either an existing concept or new metaphor.
2. Refutational synthesis: differences between studies were identified and synthesized into a relevant concept that captured the essence of the conflict.
3. Line of argument synthesis: collates both reciprocal and refutations translations within the review studies into a new interpretive context.

Interpretation of Findings

The meta-ethnography process identified key themes, centered around three third order constructs: (1) Anticipation of Ending; (2) Service User Control; and (3) Sense of Responsibility. Within each construct, sub-themes were identified and are demonstrated in a cross-comparison table. (See table 2).

Table 2

Themes and sub-themes developed from a meta-ethnographic synthesis

Theme or sub-theme	Madders 2014	Tetley 2011	Knox 2011	Råbu 2013	Olivera 2013	Råbu 2017	Cuddeback 2013	Etherington 2011	Roe 2006a	Bonsmann 2017	Scamardo 2004	Roe 2006b
Anticipation of Loss												
Emotional response to ending	*	*	*	*		*		*	*	*		
Loss of relationship			*	*		*	*		*	*		
Perceived therapists' emotional responses			*	*	*			*	*			
Service User Control												
Ending as independence and growth	*	*	*			*		*	*			*
Service User initiated ending				*	*	*		*	*	*	*	
Preparation empowering the service users	*	*	*				*	*			*	
Sense of Responsibility												
Responsibility felt towards therapist response				*	*				*			
Ambiguity around the decision to end	*			*	*		*		*	*	*	

Note. * indicates the presence of a sub-theme within the reviewed studies that contributed towards the development of the third order construct

Construct 1. The anticipation of ending.

'Anticipation of Ending' was relevant in ten of the review studies (studies 1, 2, 3 etc.) and identified in at least one of the three sub-themes: (1) the emotional impact of ending therapy; (2) loss of a meaningful relationship; and (3) service users' perceptions of therapists' anxieties. Each sub-theme indicated that service users' viewed the ending of therapy to be an emotionally evoking experience centering on ending anticipation.

Sub-theme 1.1.*The emotional impact of ending therapy.*

Developed through reciprocal translations the current sub-theme was identified in eight of the review studies (1, 2, 3, 4, 6, 8, 9 and 10). The theme collates how the experience of ending evoked powerful emotions such as anxiety, fear, and frustration. Regardless of conditional factors surrounding the experience, it appears that the anticipated loss of therapy was the common antecedent which evoked the emotional reactions discussed in the studies.

Service users who ended therapy typically responded negatively when therapy was either perceived as incomplete or when service users were dissatisfied with the process. Findings from study two reported how the challenges of transition from a high secure hospital left service users with "feelings of frustration, dissatisfaction, and anguish". Service users who reported feeling satisfied with the ending also reported concerns and anxieties about the future and their capability to survive beyond therapy. In summary, the ending of therapy evoked a strong emotional response in service users.

Sub-theme 1.2. *Loss of a meaningful relationship.*

Six studies (3, 4, 6, 7, 9 and10) reflected on the emotional impact of ending a meaningful relationship in therapy. Although the emotional responses to ending the relationship were largely negative, they reflected positive feelings about the therapeutic relationship and therapy. For example, study three reported how service users' felt, "nervous and grieved the loss of their therapist".

The therapeutic relationship is like no other in that service users' may open up more than they have ever done with anyone else in their lives. When a relationship ends, it can bring up emotions of loss, grief, and anxiety; particular in cases where individuals may have experienced early experiences of loss or relationship ruptures. Findings highlighted the importance of the therapeutic relationship in both the ending process and throughout therapy:

> "The relationship that developed with my therapist was the most secure and strong I had in my life, and the thought of termination was difficult." (Study 9).

Sub-theme 1.3. ***Perceived therapists' emotional response.***

The final sub-theme interprets the therapists' invitation for contact beyond therapy as a mechanism to change their own emotional response towards the ending. A recurrent theme found that five studies (3, 4, 5, 8 and 9) reflected upon the staff "leaving the door open" (3, 9) to therapy. Considering the studies individually, the therapist invitation of contact beyond therapy may be a function of offering a sense of security to the service user. However, a broader view may conclude that such an offering may be representative of therapists' own emotional response to ending. Firstly, only study seven reported that service users' requested additional contact beyond therapy, suggesting there little or no need for therapy extensions. Secondly, when considering the extracted themes, service users did not express a need for dependency. Indeed, the opposite was observed (discussed below). In summary, the anticipation of the ending may evoke an emotional response in the therapist, who in response, offers contact beyond therapy.

Construct 2. Service user control.

'Service User Control' was relevant as a construct in all of the review studies and identified in at least one of the three sub-themes: (1) Ending experienced as a process of independence and growth; (2) Service user initiated ending, and (3) Preparation empowering the service user. The collective interpretation of the three sub-themes captured the service users' desire to be in and assert control.

Theme 2.1. Ending as a process of independence and growth.

Nine studies (1, 2, 3, 5, 6, 8, 9, 11 and 12) alluded to service users' experiences of endings as a process of independence and growth. Translations of the data contributed toward the following interpretative narrative explanation of what may have brought about service users' experience of independence and growth. Six studies (2, 3, 5, 9, 11 and 12) reported the predominant reason for the ending was because the goals of therapy had been achieved. Goal attainment may have influenced service users' to develop a more positive outlook on the future and themselves:

"I'm a different person to when I first got here." (Study 1).

The newly adopted positive outlook is likely to increase an individual's self-reliance and confidence about the future and in turn, reduce their dependency on others. Study three reported how a former psychotherapy client felt:

"Good about leaving and ready to handle problems on her own… confident that [she] would be okay." (Study 3).

The synthesis revealed how service users felt a sense of completion and a need for independence from therapy. This may be acted out through clients' initiation of the ending, as reported in the final, third order construct.

Theme 2.2. Service user initiated ending.

The synthesis poses a question about whether the decision to end is an individual responsibility and therefore initiated by the service user, or whether it is a collaborative responsibility completed as part of the therapeutic process.

Seven studies (4, 5, 6, 8, 9, 10 and 11) reported that the decision to end therapy was initiated by the service user. For example, study eleven concluded that "service users', not therapists were the best judges" of when to end therapy and had, therefore, made the decision to end in six out of nine cases. Similarly, study five reported how a majority (71%) of service users initiated the ending. In summary, service users appear to have taken the ending decision as a personal responsibility:

"It was my decision; it was a unilateral decision." (Study 5).

Theme 2.3. Preparation and involvement empowering the service user.

The following sub-theme reflects a general consensus amongst five of the included studies (1, 2, 3, 7 and 11) that service users felt more in control when prepared for or involved in the ending process.

Three studies (1, 3 and 11) reported how being prepared for the ending was helpful for service users managing any anxieties brought up around the ending. In direct contrast, two studies (1 and 2) reported how a lack of preparation and involvement evoked feelings of disempowerment and distress. For example, study one described how service users felt "disempowered" because of the lack of involvement they had in the discharge process.

In summary, preparation appears to facilitate the management of any anxiety or distress around the ending and therefore when anxieties are better managed the individual feels more in control of an albeit uncontrollable phenomena (in as much as endings in therapy are inevitable). As summarized in study three, preparation helped service users get the "hang" of ending therapy.

Construct 3. Sense of responsibility.

A 'Sense of responsibility' was implied across seven of the review studies (1, 4, 5, 7, 9, 10 and 11) and identified in one or both of the two sub-themes: (1) Responsibility felt towards the therapist and (2) Ambiguity around the decision to end. The theme captures the underlying sense of responsibility within the dyadic relationship.

Theme 3.1. Responsibility felt towards the therapist.

Three of the review studies (4, 5 and 12) reported how service users felt anxious around how the therapist would respond to their decision to end therapy. The apprehension and caution taken in approaching the ending conversation may imply that service users' viewed certain vulnerabilities in the therapist, and therefore felt responsible for ensuring the therapist was in agreement about the ending.

The findings reported how service users' apprehension was typically influenced by their need to seek out consensus from the therapist around the ending decision:

> "I was alone with the decision [to end therapy] and afraid to share it with the therapist." (Study 5).

When the therapist responded positively, services users reported a sense of relief, however, if the therapist response was negative this evoked feelings of disappointment and guilt. Findings revealed how the therapist response influenced service users overall ending experience:

> "The therapist's feeling of rejection due to my desire to terminate and my difficulty terminating as a result." (Study 9).

Theme 3.2. Ambiguity around the decision to end.

Developed through refutational translations, the following sub-theme was identified in seven of the review studies (1, 4, 5, 7, 9, 10 and 11). The sub-theme considers the ambiguity around who is responsible for ending therapy.

Earlier translations identified a unilateral service-user led decision to end therapy. However, in contrast, five studies (1, 4, 5, 7 and 10) described the decision to end as a collaborative responsibility whereby both service user and therapist were in involved in the decision and process of ending. For example, study one identified two themes that alluded to endings as a collaborative responsibility: (1) Trust and Support: "I couldn't have done it on my own"; and (2) Feeling empowered: "We're all very close, you're always in the loop." Likewise in study ten, one participant reported a collaborative process, "we both decided it

wasn't the right time for me." Such exerts indicate that the endings were a shared experience in both process and decision making and therefore eluded toward the ending being a collaborative responsibility.

Line of Argument Synthesis

A line of argument synthesis collates both reciprocal and refutations translations into a new interpretive context (Noblit & Hare, 1988). It aims to look beyond the written word to uncover the unsaid meaning of service users' ending experiences. Therefore, the current synthesis also considered the relationship between third order constructs and provided an interpretive narrative of service users' experiences.

The synthesis highlighted how the relationship between the service user and therapist is central to therapy. Therefore, parallel to the ending of therapy the individual also ends a therapeutic relationship, evoking feelings of loss, grief and anguish. Higher-order interpretations suggest that therapists also anticipate the loss of the relationship, which is acted out by the offering of additional contact beyond therapy- 'leaving the door open'. It is hypothesized that what is witnessed in the first third-order construct is a display of resistance, from both service users' and therapists against the ending of the relationship and therapy.

The therapeutic relationship is like no other in that there is often a level of exposure, openness, and trust beyond what is experienced in most close romantic relationships (Livesley, 2003). Therefore, the ending of such relationships is somewhat unnatural but inevitable. As the ending point approaches the synthesis infers that a possible role-reversal occurs within the therapeutic relationship. As demonstrated in the third-order construct, service users' felt a sense of responsibility toward the therapists' ending experience.

Interpretations of therapists' resistance and their negative responses towards the ending indicate that the ending has an emotional impact on the therapist. Despite the review solely focussing on service users' experiences, service users reported how their own experiences were dependent upon therapists' reactions. This implies that therapists' emotional responses are not well-contained. The validity and implications of this interpretation are unknown. However, the role-reversal of the dyadic relationship raises, firstly an important point about therapists' containing their responses to endings, and secondly a question around who holds ambivalence around the ending.

The anticipated ending point also brings about a sense of ambiguity around whose decision it is to end. The synthesis concludes that there is no consensus around who holds responsibility for the ending and therefore poses a question about whether the decision to end

is an individual responsibility and therefore initiated by the service user, or whether it is a collaborative responsibility completed as part of the therapeutic process. Ambiguity around the ending decision may be influenced by the therapists' resistance to end therapy. However, it may also be a reaction to service users' reach for independence.

Viewing the ending as a collaborative endeavor may be one way to alleviate the distress surrounding the ending process. As demonstrated, service users felt less distressed when the ending was prepared for in collaboration with the therapist (e.g. joint decision-making). Likewise, service users' sought out therapists' collaboration around the ending decision, which brought about emotional relief. It is hypothesized that collaboration alleviates distress through bringing about a sense of control for the service user.

In summary, the current synthesis hypothesizes that the construct of 'service user control' may interact with both the 'anticipation of ending' and the 'sense of responsibility' felt during the ending process.

Discussion

The review used a meta-ethnographical approach to appraise and synthesis the existing qualitative research on service users' perspectives of endings from a psychological service or therapy. The review provides an interpretive understanding of how endings are experienced by service users presented under the following three main constructs: (1) Anticipation of ending; (2) Service user control; and (3) Sense of responsibility. The synthesis has highlighted key points for discussion that may have implications for the direction of future research and clinical practice.

Service User Control

A key findings developed from the synthesis was service users' desire to be in and assert control over the ending process. Control as a concept underpinned many of themes discussed within the synthesis. Similar to Quintana's (1993) 'termination as transformation model', service users described the experience of endings as a process of independence and growth. This synthesis provides evidence that for some, the ending is a representation of 'moving on' (Walsh, 2007).

The findings outline the importance of ensuring endings are prepared for, discussed and experienced jointly with service users. It also suggests that therapist factors may have influenced service users' sense of control over the ending experience. However, it would be

unfair to assume therapists' contributions without considering their first account experiences. Therefore, one recommendation would be for future research to conduct a review and meta-synthesis of therapists' first account experiences of therapy. If considered jointly alongside the current review it may provide a better understanding of the key concepts discussed in the current review.

Therapists' Emotional Responses and Attachment Theory

Interpretations of therapists' resistance and negative responses towards the ending, suggests that therapists hold anticipation around the ending of therapy. Indications are not given in this review around any contributing factors explaining why this is, however, therapist reluctance to end therapy is commonly reported, and typically related to therapist ambivalence (Phillip, 1997).

Attachment theory (Bowlby, 1973) has been used to explain service users' reluctance to end therapy (Holmes, 1997) and the therapeutic relationship (Obegi, 2008). Applying the principles of attachment theory to the perceived therapists' emotional responses may, therefore, offer one perspective for understanding their experiences when ending therapy. The majority of therapists are considered to have a 'secure' attachment style (Rubino, Barker, Roth & Fearon, 2000). However, this does not fit with the perceived ambivalent response to therapy. Within therapy, the relationships consist of the 'making and breaking of affectional bonds' (Bowlby, 1979) and therefore the therapist regularly builds up and then ends a relationship that encompasses trust, intimacy, and support (Livesley, 2003). As synthesized within the review the ending, regardless of the success of therapy the ending evokes emotions of loss. Therefore, it is hypothesized that the regularity of making and breaking of relationships creates contextual anticipation often seen in individuals classed as having an 'ambivalent' attachment style (Ainsworth, Blehar, Waters & Wall, 1978).

The review has demonstrated how therapists' emotions have been largely uncontained and in response, the service user' develop a sense of responsibility towards the therapist and inevitably reversed the practitioner-patient role. Service users assuming responsibility for the therapist's feelings or well-being can be quite risky (Shulman, 1999). The current review would recommend that further research and practice support mechanisms are explored around how therapists contain their own feelings around ending therapy.

Boundaries Imposed by Time-Limited Therapy

The synthesis concluded that there is no consensus around who holds responsibility for the ending and therefore poses a question about whether the decision to end is an individual responsibility and therefore initiated by the service user, or whether it is a collaborative responsibility completed as part of the therapeutic process.

The majority of endings discussed within the review were from private practice psychotherapy clinics from outside of the UK. The number of sessions was not restricted by any government or practice guidelines, and therefore the decision to end was the sole responsibility of the therapeutic dyad.

The current NHS practice within the UK operates time-limited therapy directed by clinical practice guidelines and dictated by local NHS trusts, commissioners or funders. Considering the synthesise findings it is proposed that time-limited therapy is beneficial, as it removes responsibility from both the therapist and service user. The UK healthcare system as it is currently may, therefore, be more effective for endings in therapy than endings in private practice.

Limitations and Considerations

The authors of the review do not claim to offer exclusive or entirely accurate explanations for each of the concepts described. As discussed in the introduction, the synthesis is an interpretation of an interpretation and, therefore each layer of interpretation moves further away from the true accounts given by the service users.

The synthesis does not demand that its views are solely accepted as true. In keeping with the nature of meta-synthesis approaches, the authors will expect that the reader will make interpretations of their interpretations.

One important limitation of the review is the vast geographic spread and diversity of services included. The un-restricted inclusion of various forms of therapy (private, NHS-delivered) and services (high secure, ACT teams) and the contextual differences within each would likely influence individual experiences of endings; therefore limiting the reviews scope for informing clinical practice generally. It does, however, provide key indications for the direction of future research. Further research exploring service users' experiences of endings from a range of different services is necessary to justify further reviews of the literature. Future meta-synthesis' may then be able to make recommendations for clinical practice. As previously mentioned, the current review makes assumptions of therapists'

responses to the ending, and therefore a complementary synthesis would support and therefore strengthen the current synthesis.

Considering contextual factors, an alternative motive for therapists not initiating the ending may be the cost implications of ending therapy with a long-term service user in private practice. Furthermore, the majority of services within the review studies were also from a psychodynamic or psychoanalytical approach and therefore not limiting the ending or setting an ending point would be in keeping with the Freudian principles (1937) of therapy. Future UK research on endings within NHS would allow further explorations of contextual factors.

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Appendix A- Search Terms

Key Terms and alterative terms used in the search strategy

Endings	ending* OR ended* OR termination* OR discharg* OR discontin* OR dropout* OR drop-out* OR dropping out OR complet* OR incomplet* OR non-complet* OR attrit* OR compliance* OR non-compliance OR transition* OR treatment termination
Therapy	therap* OR treatment* OR psychotherap* OR psychoanaly* OR psychoeducation OR psychological techniques OR group therap* OR individual therap* or mental health service*
Experiences	perspective* OR attitude* OR experience* OR view* OR understand* OR percept* OR belief* OR account* OR respons* OR evalu* OR idea* OR feel* OR opinion OR idea* OR thought* OR value* OR emot* OR expect*
Service users	client* OR patient* OR participant* OR serviceuser* OR service-user* OR consumer*

Journal Paper 1

Grounding Clinical Guidelines in Service Users' Experiences of Endings

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Grounding Clinical Guidelines in Service Users' Experiences of Endings

Abstract

Background. Endings are considered an important phase of the therapy process: however, the empirical literature on the topic is sparse, and the clinical guidelines supporting practice are limited. In particular, guidelines lack evidence derived from service users' subjective experiences and therefore require further attention.

Aim. To explore service users' experiences of the process of ending from NHS community personality disorder services.

Method. Semi-structured interviews were conducted with eight participants recruited from four NHS community Personality Disorder services.

Results. Three main themes emerged; 'Service users' experiences in the context of Reflective versus Reactive practice', 'Endings held in mind' and 'What next?'

Conclusions. Service users' experiences of endings highlight several areas of interest that may inform clinical practice, future research and potential clinical guidelines.

Keywords. endings, termination, discharge, clinical guidelines, NICE guidelines, service-user experiences, thematic analysis

Introduction

The National Institute of Health and Care Excellence (NICE) deemed it necessary to produce clinical guidance on managing endings specifically for individuals with a diagnosis of Borderline Personality Disorder (BPD). The guidelines (2009) acknowledge that the end of treatment "may evoke strong emotions and reactions" (1.1.7.1) and recommend that discharge is structured, phased and managed collaboratively with the individual and transitional provider.[1] To our knowledge, BPD is the only presentation that has attracted specific NICE guidelines around endings.

The Importance of Endings

Endings are considered a prominent, yet predictable feature across many adult-life crises (Sheehy, 1977). They are embedded within expected lifespan experiences such as relationship dissolution (Norona, Olmstead & Welsh, 2017) and grief (Kubler-Ross, 2009) and are commonly discussed within the literature.

Endings are universally significant as they represent a point of change in an individual's life. Examples may include observable changes in an individual's circumstances (e.g. family structure, job, relationship status); however, an ending can also stimulate hidden changes in an individual's perception, perceived responsibilities and sense of stability. For most people, change is welcomed and marks a point of transition and growth (Quintana, 1993). Whereas for others, the changes brought about by endings may be destabilising; the unconscious transition does not occur, and instead the ending evokes a plethora of defensive grief reactions (Mann, 1973). The symbolism of ending, the inherent change and the attached individual meaning, suggests an ending is an important process for most. With the understanding that endings are universally significant, the exclusivity of endings guidelines seems somewhat unfounded.

Within mental health care services endings are widely considered to be an important phase of therapy for both service users (Webb, Schröder & Gresswell, 2018)

[1] See extended paper section 1.4.2 for full recommendations

and therapists (Råbu, Binder, & Haavind, 2013) across a wide range of clinical areas and therapy modalities; and often elicit a complex emotive response (Wachtel, 2002).

Endings may be particularly important for individuals with a diagnosis of Personality Disorder (PD) and consequently the staff supporting individuals accessing PD services for the following reasons. Firstly, according to the DSM-V (DSM-V, American Psychiatric Association, 2013) a PD is defined as a way of thinking, feeling and behaving that deviates from the individual's cultural expectations and causes them distress or problems in functioning over time. The challenges and distress an individual experiences relate specifically to difficulties an individual with PD experiences with self (identity and self-direction) and interpersonal (empathy and intimacy) personality functioning. Further explained, those with a PD diagnosis may struggle to empathise with others, effectively regulate their emotions and will often attempt to avoid real or imagined abandonment. Considering these key features of PD, and in particular, the fear of abandonment, it can be anticipated that the ending of an interpersonal relationship with a healthcare professional may be a difficult and potentially destabilising experience. These anticipated difficulties are acknowledged within the management and support provided to individuals with PD (Bateman & Fonagy, 2000) and are explicitly outlined in practitioner guidelines (Wood, Bolton, Lovell & Morgan, 2014) and models of therapy used within PD services (Young, Klosko & Weishaar, 2003).

Yet despite a considerable amount of literature acknowledging the potential challenge of ending therapy with individuals with a PD diagnosis, there is little guidance offered to staff around how they can best manage and support this phase of therapy. Certainly, there is a clinical rationale for conducting research that supports the development of more thorough guidelines, particularly because staff consistently report anxieties around supporting individuals with a PD diagnosis, more so than in other populations (Crawford, Adedeji, Price & Rutter, 2010). In particular, staff concerns relate to the increased level of risks that are commonly perceived to be associated with individuals with a PD diagnosis (The National Institute for Mental Health in England [NIMHE], 2003).

Key Models for Understanding Endings

Despite limited early acknowledgement of the 'terminal phase' of treatment[2], endings have become a longstanding topic of interest amongst psychoanalysts (Freud, 1937) and many other theoretical derivatives, e.g., time-limited therapy (Mann, 1973) and attachment theory (Holmes, 2010). As summarised in Delgado and Strawn (2012), theoretical perspectives differ in terms of their conceptualisation of the ending; however, the vast majority concur with the psychoanalytically derived 'termination as loss' model (Quintana, 1993). According to the model, the end of therapy is experienced as a loss; in the sense that what was before is no more. In one half the model, loss signifies a potential point of crisis in which clinical attention is necessary to work through and manage relapse prevention and risk (Mann, 1973; Strupp & Binder, 1985). Interestingly, however, there is little empirical evidence to support the 'ending as crisis' perspective; the literature suggests that only a small proportion of individuals experience an ending to this extreme (Marx & Gelso,1987). More recently there has been a shift towards an 'ending as transformation' model (Quintana, 1993; Maples & Walker, 2014) which asserts that an ending instead prompts psychological development and growth through processes of internalisation; by which an individual is able to compensate for the internal and external losses of therapy and move forward.

Lack of Empirical Research

Surprisingly, theoretical interest in the study of endings has had little impact on the development of clinical guidelines. One possible explanation for this transitional deficit from theory into practice may be attributed to the scarcity of empirical research (Roe, Dekel, Harel & Fennig, 2006). The available literature provides a necessary description of the fundamental processes involved in ending therapy[3] (for a summary see Gelso & Woodhouse, 2002); however, there has been little attention given to more in-depth explorations into how endings are actually experienced. In line with the 'ask the client' movement (Elliott, 2010), to effectively manage an ending, an understanding must first be developed around how ending processes are experienced by those in receipt of therapy.

[2] See extended paper section 1.3 for further discussion
[3] See extended paper section 1.6.2 for further details

There have been some attempts at understanding service users' experiences[4] (Etherington & Bridges, 2011; Knox et al., 2011; Olivera, Braun, Gómez Penedo, & Roussos, 2013; Råbu, Binder, & Haavind, H, 2013), however, many studies have utilised survey-based methodologies (e.g. Fortune, Pearlingi & Rochelle, 2002) and therefore lack the subjective details of participants' experiences. Surprisingly, some studies have also used indirect methods (staff perspectives) to capture service users' experiences (Quintana & Holahan, 1992; Westmacott & Hunsley, 2017). As demonstrated by Råbu, Binder and Haavind (2013) service users and therapists provide different accounts of the ending experiences and therefore studies employing indirect strategies may not provide an accurate reflection of service users' experiences. In summary, although indicative of the range of experiences, the literature discussed provides only a limited understanding of service users' experiences of ending.

A recent systematic literature review by Webb, Schröder and Gresswell (2018) provides a synthesis of the available published evidence on service users' first account experiences of endings. In summary, peer-reviewed evidence suggests that endings are experienced as an emotionally evocative event that centres on the anticipation of loss. Having control over the ending experience and the service users' sense of responsibility towards the therapist or around the decision to end were also identified as key constructs representative of service users' experiences. However, the available studies were geographically spread and predominately from private practice which therefore limited the review's potential for informing clinical guidelines or practice within time-bounded UK NHS settings. The review concludes that further exploration is required into service users' experiences of endings across different contexts to inform clinical practice guidelines.

Summary and Clinical Relevance

Endings are an important phase of the therapeutic process and are particularly significant for individuals with a diagnosis of PD who may struggle with interpersonal functioning and abandonment issues. However, empirical evidence is limited, and guidelines informing practice around the management of endings are sparse. In clinical

[4] See extended section 1.6 .3 for further details

practice, staff working within PD services regularly express anxieties around supporting individuals with a PD diagnosis and have expressed specific concerns around managing risk. Considering endings are also a potentially destabilising experiences for individuals with a PD diagnosis, there is a clear clinical need and a rationale for conducting research that may inform guidance around how best to manage endings within PD populations.

Research Aim

Acknowledging the lack of focus on service users' experiences and the highlighted importance of managing endings within PD services, the researchers aimed to explore service users' subjective experiences of endings from NHS community PD services. During the analysis, it became apparent that there were two distinct over-arching themes; service users' experiences of the process of ending and their clinical reactions and responses to the ending. The researchers therefore made the decision to separate the findings into two unique papers. This first paper, presents three key themes that relate to informing the procedures involved in the management of endings in practice. This paper may be particularly relevant for staff seeking advice around how to best manage endings in clinical practice. The connected paper (Webb, Schroder & Webb, Unpublished) provides the reader with an understanding of how endings are experienced as a loss and how an individual's emotional response to loss is managed in part by the role of boundaries.

Through developing a deeper understanding of service users' experiences of the ending process could expand the evidence-base, inform clinical guidelines and may improve clinical practice and service effectiveness.

Method[5]

Ethical Approval

Ethical approvals were sought and obtained from a local NHS Research Ethics Committee (17/YH/0221) and also from each participating recruitment site. This project followed ethical guidelines from the British Psychological Society [BPS] (2014).

[5] See extended paper section 2.2 for further detail on methodological decisions and rationales

Recruitment

Participants were recruited from four NHS community PD services. Considered the largest providers nationally (Crawford et al., 2007), NHS community PD services provide support to individuals with a diagnosis, or traits of PD from age 18 onwards. Support offered to service users typically consists of multi-disciplinary management, care-coordination and a range of evidence-based 1-1 or group interventions.

Procedure

Individuals discharged within the preceding three-months were identified and checked for eligibility by a team clinician. The inclusion criteria required participants to be aged over 18, discharged from the service within the last three months and able to give informed consent. Eligible participants were posted a research invitation pack from the service detailing study information and inviting them to respond or contact the research team for further discussion. All participants had been discharged from the service and so an 'opt -in' method of recruitment was deemed the most ethically appropriate. Respondents were provided with the opportunity to ask questions and discuss the project. Written consent was obtained before the interview was arranged. Participants were given 24 hours from providing consent to reflect on their involvement before the interview took place.

Data Collection

Participants were interviewed over the telephone by the lead researcher. Interviews were on average 37 minutes in duration and were guided by a semi-structured interview schedule[6] (see Appendix B) that was informed by the current NICE guidelines (2009) and gaps in the literature.

Participants

A total of 103 individuals were invited to participate, 13 responded to the invite (a response rate of 12%), and eight consented to take part.[7] Participants (7 females, 1

[6] The interview schedule will be provided as an appendix to the journal paper.
[7] See extended paper section 3.1for recruitment data results

male) ranged between 23-64 years in age; the average age of participants was 41 years. Seven participants considered themselves White-British and one individual identified as a British-Pakistan female. Time spent in therapy ranged from 3 months to 14 months. Support received by participants reflected the full range of services on offer within community PD services including 1-1 CBT, year-long psychodynamic psychotherapy, community group, structured clinical management, DBT groups, schema-informed groups and skills-based groups.

Analysis

Interviews were transcribed and analysed using a mixed deductive-inductive hybrid approach (see Table 3), adapted from the thematic analysis framework of Braun and Clarke (2006). A *refutational stage* (step 4) was added as a process to ensure that the researchers considered contrasting data.[8] It aimed to ensure a balanced perspective of the data was considered and worked to minimise research bias. This stage was completed in consultation with the second and third authors. Although Braun and Clarke (2006) provide guidance on how inconsistencies should be managed, the process was not formalised within the original steps of analysis. Having noted the importance of conflicting experiences, the researchers have attempted to formalise this by including the 'refutational' stage as a procedure of analysis.

Refutational stage of analysis.

Following the process of collating codes (both deductive and inductive) into potential themes (step 3), the researcher then searched for codes that refuted either the categories of codes or themes developed in the previous step. Where oppositional codes were found, the researcher firstly considered: 1) whether they were proportionate to the original codes or theme, and 2) whether the contrast highlighted a clinically relevant matter in line with the research aims. If the oppositional codes were deemed to be relevant, then the researcher demoted the original theme, and created a new theme to reflect the refuting collection of codes or themes[9]. This process was checked in supervision by the second and third author.

[8] See extended paper section for further details
[9] See extended paper section 2.5.4 for a step by step example

Table 3

Thematic Analysis Steps adapted from Braun and Clarke (2006)

Step	Description
1. Familiarisation with the data	Read and re-reading, noting down initial ideas.
2. Coding the data	Firstly, search through data and identify meaningful units of text that fit the deductive coding framework. Secondly, inductively code interesting and relevant parts of the data systematically across the entire data set, collating data relevant to each code.
3. Searching for themes	Collate deductive and inductive codes into potential themes, gathering all data relevant to each.
4. Refutational stage	Check for contrasting themes across the data set or codes that refute current themes.
5. Reviewing themes	Check the themes work with both the coded extracts and the entire data set and generate a thematic map of the analysis.
6. Defining and naming themes	Ongoing analysis to refine each theme, and the overall narrative the analysis tells, generating clear definitions and names for each theme.
7. Producing the report	Select key extracts that represent the data and relate to the analysis of the research question and literature, producing a scholarly report of the analysis.

Results

Three main themes and eight sub-themes emerged from the data and are summarised in table 4. These themes are discussed below and illustrated by interview extracts.

Table 4

Themes and Sub Themes

Theme	Sub Themes
Reflective Vs. Reactive Practice	Experiences in the context of reflective practice
	Experiences in the context of reactive practice
	Emotional impact of the ending process
Endings held in mind	Explicit from the start
	Endings not a taboo
	Marking the ending
What Next?	Filling the void [or]
	A welcomed break

Service Users' Experiences in the Context of Reflective vs. Reactive Practice.

This theme captures service users' contrasting experiences and the subsequent emotional impact of reflective and reactive clinical practice around the management of endings.

Reflective practice experiences.

Participants suggested that the process and impact of the ending were in most parts considered and reflected upon by the health professional managing the ending. In particular, there was evidence that participant endings were structured and phased, supported, and planned collaboratively.

For example:

"*I guess we all knew it was going to come to an end so they did slowly wean us off the intensity… I think it was good how it was planned out*" (Participant 2)

"*I think I was well prepared, I think we had drawn the conclusions together that I needed from the year -long therapy.*"(Participant 4)

"*They looked at options outside of the hospital like charities and things that offer support groups or urm.. different things really, you know like, they just hold, like a community centre*." (Participant 6)

There was also evidence to suggest that one service was mindful of the impact of ending therapy and had explicitly acknowledged the process by incorporated a dedicated 'ending session' in their group program.

[The final group session] "*That was thinking about endings, that was the theme for that weeks session.*" (Participant 2)

Impact of reflective practice.

Reflective clinical practice around the management of endings was received well and had a positive emotional impact on participants; who seemingly felt a sense of assurance from the health professionals' approach.

"Yes it did help, the tapering off period because although it ended in October I felt like I have only just fully finished now (March). " (Participant 8).

"*It feel good that somebody cared, you know they cared enough to try and find something else for me to do*". (Participant 1)

"*She was good, I cannot fault her she was really helpful."* (Participant 7)

"*But, you know he did tell me and you know I understood what was going to happen, and that was just, I thought like, oh right, at least he is not going to leave me adrift in the sea, kind of thing.* " (Participant 5)

Reactive practice experiences.

In contrast, some participants experienced the process of ending as unclear, abrupt and lacking in communication. This perhaps indicates that the management of endings was more reactionary towards the stimulus that was the end point of therapy.

"*I didn't know what was going on, it was up in the air kind of thing.* "
(Participant 5)

"*I felt it was a rushed ending.*" (Participant 2)

"*The second time I phoned I still couldn't get through so I left a message of his voice mail for him to get in contact with me, and I never got any reply and then I spoke to a lady called ..... who told me that Mr .... he'd left the practice.*" (Participant 5)

Impact of reactive practice.

The reactive approach to the management of endings was experienced as un-supportive and abrupt. The negative impact, associated risks and potential unravelling of therapeutic gain was apparent within participant experiences.

"*It's just none of us were helped to understand the pain and we have all kind of ran away in our own directions from the pain.*" (Participant 2)
"*We will see you when you next try to kill yourself. That is not what is said obviously but that is how it makes you feel.*"(Participant 6)
"*Like they don't care or that you had wasted 12 months because now you're just going back to the life you had before.*"(Participant 6)

Endings Held in Mind

The theme 'endings held in mind' refers to the ever-present topic as experienced by participants throughout therapy. The explicit discussion of ending from the start, mentioning throughout, and the significance of 'marking' the end of therapy collectively highlight the prominence of ending.

Explicit from the start.

Participants reflected that time-bounded therapy, that has a clear start and end was a significant aid for self-managing the ending experience. The boundaries imposed by service limitations and therapeutic models enabled service users to remain focussed, manage expectations and rationalise their emotional response to ending.

"*Well, I think the good thing with this was that I always knew it was a year, so it was very much part of, on the cards from day one. It lasts for a year and that's your lot. They very much make it time bound and so I suppose for the whole time*

I was doing it, that was on the agenda almost, if you know what I mean." (Participant 4)

"*From the second you start you know when it is you are going to end and although it makes it terrifying and a counting clock, it does make it feels like you're not being dropped, you're not being abandoned.*" (Participant 8)

Endings- not a taboo topic.

The sub-theme 'endings-not a taboo topic' captures how endings were an un-avoided and welcomed point of reference throughout therapy. Participants reflected how repeated discussions, although difficult, 'diluted' the impact of ending.

"*So yeah we thought about it and talked about it throughout the weeks and months now and again*" (Participant 3)

"*It was always there so it wasn't a surprise, so it was, actually it was good, it wasn't this taboo topic that's never mentioned.*"(Participant 4)

"*It's like its diluted it as such, but it is still really difficult.*" (Participant 2)

"*I think I would definitely keep the mentioning it part because as much as for me it wasn't something I wanted to hear, I think the way that I am feeling now would have been a lot worse if it wasn't mentioned.*" (Participant 2)

Marking the ending.

The significance of marking the ending for service users, staff and services became apparent through participant experiences. Participants reported how the end of therapy was marked in various ways such as a shared celebration, gift exchange or through receiving a certificate or therapeutic ending letter. One service marked the ending through a dedicated ending-focussed evaluation session which aimed to provide a reflection space for processing the ending.

"*Yes, in the group they had a little tea party which was quite nice with the therapists and members which was quite nice as well. In the TC [therapeutic community] there was a celebration, so we had like a meal and then we*

swapped, because I brought the TC something and they had something for me, so we swapped gifts and then I said thank-you, so yes." (Participant 3)
"*Yes, we all brought in cookies and made a point of it ending.*" (Participant 8)
"*She did this very long, very brilliant kind of long reflection on my therapy for me and gave it to me to read before I went into the last session.* " (Participant 4)
"*Yes, they gave me a certificate to say that I had completed it.*" (Participant 1)
"*It was done in the group, the final group session where we got together to like for the last meeting. That was thinking about endings, that was the theme for that week's session.*" (Participant 2)

What Next?

The final theme 'What Next?' captures the contrast between SU hopes and fears for life after therapy. For some, the 'what next' provoked anxiety and the desire to have a fail-safe plan to fill the void left from ending therapy. Others welcomed the ending to either consolidate their learning or be free from the commitment of therapy.

Filling the void.

The sub-theme 'filling the void' highlights participants' anxieties and fear around ending therapy and being left in the "big bad world without backup" (participant 6). In response to the perceived void left by therapy participants stressed the need to have something to fall back on.

"*You know there is a lot going on and I think if you have got nothing else it would maybe race around in your mind and make you worse.* " (Participant 6)
"*Well to be honest with you, I did not like the thought of it because, er I did think I would not have anyone else or someone to talk*." (Participant 5)
"*I think there should be a follow-on group, something, maybe not as intense but something sort of to ease it down a little bit, just something to fall back on.*" (Participant 1)

A welcomed break from therapy.

In contrast, other participants welcomed the break from therapy to either consolidate and apply their newly adopted learning and skills, or to be free from the commitment of therapy.

> "*I need to take a bit of time and take what I have learnt in DBT to actually happen before I can move on. Which is a bit difficult because it feels like I am not doing anything which is not true, but it feels that way… I am quite happy to let it sit for a bit before I pursue my next path of recovery.*" (Participant 8)"

> "*I felt I was just ready to move on, and put stuff behind me… I wanted a break from therapy and a break from everything.*" (Participant 3)

> "*I actually think I kind of thought it's nice to not have that commitment, kind of be a bit free from that.*" (Participant 4)

For some participants the appeal of ending therapy seemed to be related to their sense of achievement or progress in therapy;

> "*It was quite a sense of achievement I have done this and gained a lot from it.*" (Participant 4)
> "*I am not fully recovered, or fully functional for work or social but I don't hurt myself or destroy my relationships the way I used too, which is a massive difference*." (Participant 8).

For one individual, therapeutic gain was intrinsically linked to a pivotal moment around taking personal responsibility;

> "*My life had just got to the point where I was like, I am sick of this I need it to get better and I have to do something to make it change*." (Participant 8)

Discussion

This research aimed to explore service users' experiences of the process of ending from NHS community PD services.

Overall the findings highlight the importance of adopting a reflective pro-active approach to the management of endings and notes the positive impact that this had on service users' experiences. In contrast, when endings are seemingly reacted too and not carefully considered, service users reported how this negatively impacted their experiences. Results suggested that weaving discussion about endings from the start, throughout and also at the end of therapy was also an important process within participants' experiences of ending. Likewise, the transition into life beyond therapy was highlighted as a pivotal point of reflection within the ending process. Collectively, service users' first account experiences of endings provide a qualitative understanding of the processes of ending.

Reflective vs Reactive

The positive responses of service users' in receipt of reflective practice highlights the importance of having effective management strategies that specifically ensure the ending processes are considered and prepared for. The findings are consistent with the current NICE guidelines (2009); however, the contrasts between service users' experiences indicate variation in how endings are managed in practice.

One possible explanation for the variation in service users' experiences could be due to how clinical guidelines are perceived and utilised by the health professionals. Although NICE guidelines are often considered a rigid prescription for practice (Court, Cooke, Scrivener, Wells & Wells, 2016), they are often not adhered to (Prytys, Garety, Jolley, Onwumere, & Craig, 2011). Research investigating non-compliance is limited (Berry & Haddock, 2008), however, two barriers to implementing the guidelines include organisational factors (e.g. lack of resources, time and training) (Ince, Haddock & Tai, 2016) and recommendations that are unclear or ambiguous (Lugtenberg, Zegers-van Schaick, Westert & Burgers, 2009). Certainly, the current guidelines for endings (NICE, 2009) lack empirical support and offer vague direction as to how health

professionals should implement the recommendations. In summary, non-compliance and variations in how ending guidelines are accessed and interpreted may in part explain the contrasts between participants' experiences of ending.

Also referred to as the research-practice gap (Kristensen, Nymann & Konradsen, 2016), this discussion highlights a particularly salient point for the current and future research that perhaps assumes that writing better guidelines will improve patient care. As illustrated, service users' experiences of endings vary and are somewhat contingent on staff adherence and perceived value around the utility of clinical guidelines[10]. Accordingly, it may be more feasible to re-direct research effort and intervention towards organisational factors (e.g. improvement strategies)(see Ince, Haddock, & Tai, 2016).

Findings from the current study provide evidence to suggest that services are adopting their own practices around the management of endings in therapy (e.g. dedicated ending session). Arguably, the practices reported may be how the services have interpreted the current NICE recommendations; however, there is evidence within the field to support that services are developing in-service recommendations to support how they manage endings (e.g. Keane, Prince & Fusekova, 2015). The use of practice-based evidence is considered a valuable strategy for enhancing the local provision of care (Holmqvist, Philips & Barkham, 2015); however, it does bring to light a question around the sufficiency of the current NICE guidelines. Arguably, the lack of detail and specificity within the guidelines may encourage practitioners to reflect on their practice and prevent the recommendations from being adopted as a prohibitive instruction (Mollon, 2009). The developments in practice-based evidence suggest that there are sufficient gaps within the literature and current recommendations that warrant further exploration. On this basis, we encourage health professionals to use the NICE guidelines alongside research and practice-based evidence to support service users throughout the process of ending.

[10] See extended paper section 1.5.2.1

Endings Held in Mind

The research highlights how endings were 'held in mind' from the start and throughout the entirety of therapy. The repeated mentioning and discussion of the anticipated ending may have functioned to gradually and repeatedly expose an individual to the loss of therapy and reduce the emotional impact of ending. Particularly within group-therapy settings exposure to the emotional responses to loss is intrinsic. Further explained, previous experiences of loss are said to influence how an individual may respond to current separation and loss (Firestein, 2001; Holmes, 1997). There has, however, been little consideration for the losses that occur within therapy. Indeed, separation and loss are embedded within the processes of psychotherapy (Holmes, 2010); which is often peppered with repeated separations such as the ending of each therapy session, breaks in therapy and the occasional therapeutic rupture. In a similar vein to how mentioning the topic 'dilutes' the impact of ending, the repetition of these smaller losses throughout therapy may expose an individual to the emotional aspects of endings. Particularly within open-group therapy settings, service users regularly experience group members coming and going. These subtle losses may evoke undesirable responses; however, when experienced within a supportive therapeutic environment, a loss can be processed, and emotional distress can be contained. As suggested in Sroufe's (2005) 'transactional model of attachment', a loss can be managed successfully through a supportive context. In summary, exposure to loss during therapy creates a re-learning experience for the individual around how to end well.

What Next?

The theme 'What Next?' highlights the contrasting ways in which service users respond differently to the prospect of life after therapy. Consistent with Quintana's (1993) 'ending as transformation' model, some service users felt empowered and welcomed the transition. In contrast, other service users expressed anxiety around ending and were more resistive, although not ever to the extent of crisis as indicated in the theoretical literature (Quintana, 1993).

The differences in service users' responses towards the anticipated endpoint can perhaps be understood relative to an individuals' readiness to end therapy. Drawing upon the stages of change model (Prochaska & DiClemente,1983) we speculate that individuals who sought to 'fill the void' of therapy would likely be positioned at the 'pre-contemplation' stage and considered not ready to end. In contrast, individuals who welcomed the break from therapy would sit at the 'preparation' stage. The dilemma here is that the boundaries of time-limited therapy mean therapy will end regardless, and therefore, an individual may end despite not feeling entirely ready. This ambivalence is likely to evoke fear in response to the loss of ending therapy (Webb, Schröder & Gresswell, Unpublished)[11]. The task of therapists here is to, 1) establish where an individual is at in terms of the readiness to end using the adapted stages of change model (see Figure 2), and 2) support the individual to move through the stages towards ending effectively.

Factors that impact an individuals' 'readiness to end' and strategies for supporting the transition of change can be elicited from the broader literature informing transition throughout the original stages of change model (Prochaska, Norcross & DiClemente, 2013). However, the current findings suggest that feeling a sense of achievement (goal-attainment), having acceptance around the current stage of recovery and taking responsibility for progress are key enablers that supported individuals to move towards accepting the ending of therapy.

[11] See journal paper two

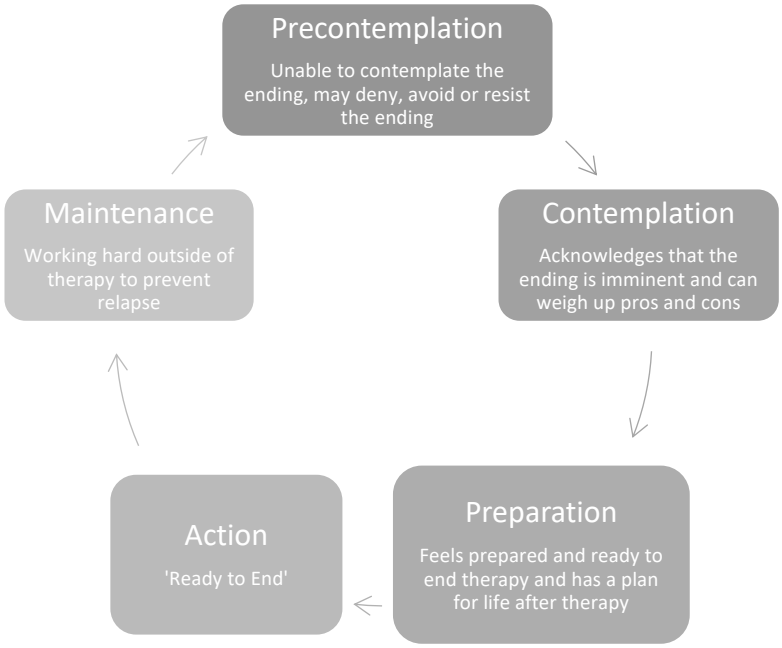

Figure 2. Readiness to end therapy- stage model adapted from Prochaska & DiClemente(1983)

A final point of discussion reflects how some service users viewed the ending of therapy as a 'break within their 'path of recovery', rather than an absolute endpoint. This finding is consistent with the literature that demonstrates re-referral rates to be high (Cairns, 2014) but is also in keeping with the perceived clinical practice of health professionals who reportedly leave the therapy 'door open' (Webb, Schröder & Gresswell, 2018). Conceptualising the ending in this temporary way may reduce the permanency of the change process and therefore alter how an individual perceives, experiences and responds to the ending of therapy. Arguably, viewing the ending as an interrupt enables an internalised connection to remain beyond therapy, that perhaps reduces the emotional impact of ending and diffuses the potential for ending 'crisis' (Mann, 1973; Quintana, 1993).

Notably, the 'interrupt' model of endings, also inferred by Linehan (1993), may be particularly helpful for individuals with a PD diagnosis who struggle with interpersonal difficulties and perceived abandonment. However explicitly

acknowledging a model that promotes health maintenance through a cyclical process of therapy and therapeutic breaks, firstly contravenes the predominant curative model of healthcare (Fox, 1997), but also implicitly portrays a message that the therapy door is always open. Although this could help manage risk over time, it may unhelpfully promote dependency on services (Mann, 1973); and would be particularly problematic within the current context of service delivery (Maynard, 2017)[12]. If the interrupt model of endings were to be adopted, it would be necessary for services to have clear boundaries in place around referral criteria but also clearly defined goal-directed therapy that holds endings in mind.

Strengths and Limitations[13]

The 'refutation' stage of analysis may be considered a notable strength of the research methodology as it aimed to ensure a balanced perspective was adopted when coding and developing themes. Deviating from the original Braun and Clarke model (2006) the additional step sought to assure 'trustworthiness' of data (Lincoln & Guba, 1985) and minimise researcher bias; strengthening the value of the qualitative research methodology.

Limitations of the research relate primarily to the representation of the sample. Firstly, the findings and recommendations were obtained from a limited sample of eight individuals who received support from four different tier-three NHS PD services. The authors acknowledge that recruitment was a challenge and that low participant numbers may limit the generalisation of findings. Despite this, similar experiences were reported across the breadth of different services and therapy modalities, therefore, providing evidence that the range of ending experiences are representative of general ending experiences.

Another limitation is that the researchers were unable to recruit individuals who experienced an unplanned ending. Individuals who choose to leave therapy early (an unplanned ending), do so for a variety of reasons (Bonsmann & Gubi, 2017) and, therefore, how they experience the ending may be entirely different to those who engaged with a planned ending process. Unplanned endings are considered problematic

[12] See extended paper section 1.4.1for a related discussion
[13] See extended paper sections 4.3 and 4.4 for additional strengths and limitations

within psychotherapy practice (Swift & Callahan, 2011) and are reported to have undesirable consequences that impact service users (limited treatment gains) (Lampropoulos, 2010) and service delivery (cost implications and time pressures) (Barrett, Chua, Crits-Cristoph, Gibbons & Thompson, 2008). Obtaining service users' qualitative experiences would provide a broader understanding of service users' experiences of endings that may inform intervention for preventing premature endings.

Clinical and Research Recommendations

This research intends to inform the current NICE recommendations for endings for individuals with BPD, which currently recommend that the ending of therapy is structured, phased and managed collaboratively with the individual and transitional provider. However, any extensions to the guidelines should not be seen as further prescriptions of how to end therapy but instead viewed as further points of consideration for practitioners when working on an ending with a service user. Although the research sought to inform practice with individuals receiving support from NHS community PD service, we hope that the reader will consider the subsequent recommendations as general guiding principles for managing therapy endings more effectively. Synthesised from the research findings, we recommend the following for services and health professionals:

1) Take a reflective approach to the management of endings;
2) Make endings explicit from the start;
3) Put endings on the agenda throughout therapy;
4) Plan the ending point (whether and how this will be marked);
5) Empower the ending (view the ending as the start of a new chapter);
6) Assess an individual's readiness to end and support transition throughout stages
7) Services should also support staff in managing the ending through supervision or additional training.

Interestingly, Dalzell Garland, Bear and Wolpert (2018) report similar recommendations for services managing treatment closures within child and adolescent services. Their findings echo that endings should be discussed upfront, planned, spoken about and supported at both an individual and staff level. Considering the similarities between the recommendations in both papers, one hypothesis is that ending experiences are similar across the lifespan; this perhaps might warrant the development for a more general guideline for practitioners on managing endings in practice that are not specific to diagnosis or population.

Empirical research into the management of endings is still in its infancy and, therefore, additional research should seek to understand ending experiences across a range of clinical contexts, services and perspectives (service users and staff). Further understandings would expand the current evidence base, inform existing clinical guidelines and provide evidence to support a more general guideline for ending therapy. Our findings indicate variation in how services were interpreting and delivering the current NICE guidelines; it may, therefore, be necessary to invite services to share their current processes for ending. A synthesis of this information would provide a collective understanding of practice-based evidence used to inform practice.

Conclusions

Collectively, service users' first account experiences of endings provide a qualitative understanding of how the processes of ending are experienced in clinical practice.

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Journal Paper 2

The Role of 'Boundaries' in Service Users' Experiences of Ending from Community Personality Disorder Services

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Abstract

Aim: To explore service users' experiences of endings from NHS community Personality Disorder (PD) services.

Method: Semi-structured interviews were conducted with eight individuals discharged within a three-month period from one of four NHS community PD services. Interview transcripts were analysed using a hybrid deductive-inductive approach using an adapted version of Braun and Clarke's method of thematic analysis (2006).

Results: A diagrammatic thematic map provides a visual representation of the three key themes that emerged from participant experiences of ending; namely 'Loss', 'Responses to loss' and 'Boundaries'.

Conclusions: Collectively, the findings suggest that boundaries play an important role in determining how service users' experience the endings. Recommendations for how health professionals and services manage endings within clinical practice are provided, along with areas for further research on therapeutic endings.

Keywords: endings, termination, discharge, personality disorder, service user experiences, boundaries

Practitioner Points:

- Service users may oscillate between a range of emotions in response to the loss of therapy.
- It is important to be aware of and effectively manage relational boundaries within therapy as this may impact how a service user experiences and responds to the ending.
- Boundary management may also be important for health professionals' experiences of endings.

Introduction

Gelso and Woodhouse (2002) define the 'ending' of therapy as the "*last phase of counseling, during which the therapist and client consciously or unconsciously work toward bringing the treatment to an end*" (p.346).

Ending and Responses to Loss

According to Quintana (1993), when an ending occurs, a loss is endured[14]. The experience of loss can often ignite a range of complex emotions (Wachtel, 2002) and behavioural responses (Baum, 2005) that result in a period of psychological instability. For some, an ending may evoke negative responses that represent a point of 'crisis' which then may instigate further support from services (Quintana, 1993), however, in contrast an ending may also symbolise a point of transition and growth (Webb, Schroder & Gresswell, Unpublished)[15]. Responses to loss can vary, and may involve adaptive responses such as reaching out to others for emotional support (Nolen-Hoeksema & Davies, 2002), however, some may also respond through protest (Pistole, 1999) or detachment (Wallin, 2007). An individual's capacity to cope and respond adaptively to loss is determined by numerous factors which include, but is not limited to, their previous experiences of loss (Stroebe, 2002), expectations of others (Bowlby, 1988) and development of adaptive coping strategies (Frayley & Shaver,1999).

Endings as a Dyadic Process

According to Gelso and Woodhouse's (2002) definition, the ending of therapy is a dyadic process that is experienced by both the service user and the therapist. It is a shared experience and therefore the loss, and the different responses to loss are experienced by both parties in parallel. How each party experiences the ending will, however, be influenced by the other due to the reciprocating and responsive patterns of interpersonal interactions that are formed throughout therapy and develop what is known as therapeutic relationship. When attempting to understand the experience of endings, it therefore seems important to understand experiences in the context of the therapeutic relationship. The therapeutic relationship is characterised as offering

[14] See paper 1 for further information
[15] See paper 1 results and discussion

emotional security, safety to explore and care (Mallinckrodt, 2010) and therefore it mirrors aspects of an early childhood relationship between a parent and a child. Furthermore, the inherent power-dynamics within the therapeutic relationship may similarly replicate early childhood dynamics between parent and child. Considering these points it seems appropriate to attempt to understand the different experiences and responses to ending from a developmental psychological perspective, namely attachment theory.

An Attachment Perspective on Endings

Through an attachment lens (Bowlby, 1973), an individual's response to loss is guided by their early attachment relationships. Specifically, a care-giver's availability (physical and emotional) and response to separation provides the infant with a 'secure base' from which they can explore the world safely. From early interactions, infants develop varying expectations (positive and negative) of themselves and others (Bowlby, 1988). If care is consistent, responsive and sensitive, an infant learns that others are reliable and trustworthy, and they are more likely to develop a secure attachment relationship. In contrast, if care is perceived to be unreliable, inconsistent or rejecting, an infant will learn that others are unavailable or untrustworthy and develop an insecure attachment relationship. Collectively termed internal working models (IWM) (Bartholomew & Horowitz, 1991), these internalised patterns of relating provide a template for managing future relationships (Sroufe, 2005).

Attachment theory views the therapist-client relationship as an inescapable 'real-relationship' that evokes an attachment response when therapy ends (Holmes, 2010). Securely attached individuals reportedly cope better with loss in general and within therapy (Holmes, 1997) due to their previous positive interpersonal experiences and affirming views of themselves and others. When therapy ends, a securely attached individual can hold the therapist in mind as an internal representation (Bowlby, 1980), enabling the secure attachment relationship to remain. Their previous learning of others as reliable and consistent means they can seek out emotional support and manage the loss through a range of adaptive coping strategies (Fraley & Shaver, 1999).

In contrast, individuals with an insecure (anxious) attachment style may struggle to tolerate separation and loss. As a result of early intermittent caregiving experiences, an insecurely attached individual will likely anticipate, yet intensely fear the loss of any attachment relationship (Bartholomew & Horowitz, 1991). Due to a heightened and dysregulated emotionality, an insecurely attached individual is likely to inhibit engagement (Jinks, McMurran & Hubbard, 2012) and elicit more maladaptive coping strategies (Fraley & Shaver, 1999). These attachment difficulties and responses are reported typical of a PD presentation (Levy, Johnson, Clouthier, Scala & Temes, 2015)[16]; and therefore, the ending of therapy may be anticipated to be particularly challenging for individuals who attract a PD diagnosis.

Considering that staff will inherently adopt the 'caregiver' role within the attachment relationship, managing endings within services that support individuals with a PD diagnosis may be particularly challenging and anxiety-provoking. The ending of the therapeutic relationship will trigger a reciprocal insecure attachment response within the therapist, which may explain why staff report more anxieties when working with individuals with a PD diagnosis than in any other population (Crawford, Adedeji, Price and Rutter (2010). This highlights a potential clinical need that requires developments in research that specifically provide recommendations on managing endings in PD populations.

Management of Endings

The management of endings in clinical practice are contingent upon several different variables. Firstly, system factors such as the service delivery model, clinical recommendations and different therapeutic models provide guidance around 'when' and 'how' therapy should end[17]. Specifically, the National Institute of Health and Care Excellence (NICE; 2009) provide recommendations for how endings should be managed with individuals with a PD diagnosis; however, the guidelines are limited in scope and lack specificity[18]. At an individual level, the responsibility for ending therapy is managed in-session between the service user and the therapist; here the intricacies

[16] See paper 1 introduction section
[17] See extended section 1.4.3 for further discussion
[18] See extended section 1.4.2 for further discussion

around ‘how’ the ending of both therapy and the therapeutic relationship ends can be negotiated and planned (Råbu, Binder & Haavind, 2013).

Unfortunately, these intrapersonal strategies are not well articulated within clinical recommendations (NICE, 2009) and have, in some cases, led services to develop their own ‘best practice’ recommendations[19](Keane, Prince & Fusekova, 2015). Although the literature provides an overview of the processes involved in ending (Marx & Gelso, 1987; Quintana & Holahan,1992), the empirical evidence has neglected to sufficiently capture a more profound understanding around how endings are experienced in practice. Considering the anticipated challenges that endings may pose for individuals supported within a PD service and staff anxieties in managing endings within PD population. In line with the ‘Ask the client’ movement (Elliott, 2010), capturing service users’ experiences of ending will aim to offer a more in-depth insight into how endings can be better managed in practice.

Research Aim

This study aimed to explore service users’ subjective experiences of endings from NHS community PD services. This paper is connected to another research paper (Webb, Schroder & Gresswell, Unpublished) and the findings are derived from the same data set. The researchers decided to separate the findings because during the analysis it became clear that two distinct themes had emerged; service users’ experiences of the process of ending (paper 1) and their clinical reactions and responses to the ending (paper 2). This paper (paper 2) presents three connected themes that provide the reader an understanding around how endings are experienced by service users. It also includes the theme of ‘boundaries’ which was identified during the thematic mapping process as having a mediating role in service users responses the loss of ending therapy. Developing a deeper understanding of service users’ experiences of the ending process could expand the evidence-base, inform clinical guidelines and may improve clinical practice and service effectiveness.

[19] See extended paper, section 1.4.2.1 for further discussion

Method[20]

Ethical Approval

Ethical approval was obtained from a local NHS Research Ethics Committee (REF:17/YH/0221) and each recruitment site involved.

Design Overview

This research aimed to understand the subjective experiences of endings, and so a qualitative semi-structured interview methodology was employed to explore the range of participant perspectives. This research was approached and conducted according to a critical realist epistemological position.

Procedure

Participants were recruited from across four NHS community PD services via a research invitation that was sent directly from the service. This recruitment procedure was considered ethically appropriate and compliant with the Data Protection Act (2008) and Information Governance procedures (Department of Health, 2007). To be considered eligible, participants must have been discharged from the service within the preceding three-months, aged over 18 years and able to provide informed consent. Invited participants were provided with the relevant study information and asked to contact the research team to discuss participation before making an informed decision to opt-in (or not). A 24-hour time period following written consent enabled participants to have a period of reflection before the interview. The interviews were conducted by the lead researcher and audio recorded.

Interview schedule. A semi-structured interview schedule (see Appendix B) was used to guide the interview and elicit service users' subjective experiences of endings. In line with the research aims, the interview questions were open-ended and aimed to elicit qualitative data and prompt further avenues of discussion that could be explored.

[20] See extended paper, section 2.2 for methodological rationales and discussion

Participants

Eight participants (seven females: one male) were recruited from four different NHS service. Following qualitative guidelines by Elliott, Fischer & Rennie (1999), limited demographic information was taken, and pseudonyms were used throughout to protect the identity of participants. Regardless of service provision, the type of therapy received by participants reflected the full range of services on offer by NHS community PD services. Therapy included 1-1 CBT, year-long psychodynamic psychotherapy, community therapy group, structured clinical management, Dialectic Behavioural Therapy (DBT) groups, schema-informed groups and skills-based groups.

Analysis

A hybrid deductive-inductive thematic approach was adopted firstly to acknowledge the current literature on endings through a deductive coding framework. Secondly, the paucity of the empirical literature on ending experiences (Roe, Dekel, Harel & Fennig, 2006) indicates there are gaps in knowledge around how endings are experienced in clinical practice, meaning a complementary inductive process was included to allow for new experiences to emerge. Braun and Clarke's (2006) thematic analysis approach guided the steps to analysis,[21] however, an additional 'refutational stage' was added (step 4) as a quality assurance step to ensure contrasting data was considered. Although Braun and Clarke (2006) encourage researchers to acknowledge inconsistencies within and across the data set, to our knowledge there has been no formal acknowledgement of a 'refutational' stage, therefore this method of analysis is considered unique to this research.

Refutational stage of analysis.

Following the collation of codes and initial search for themes (step 3), the researcher then searched for codes that conflicted either the categories of codes or themes developed. Where oppositional codes were found, the researcher firstly considered whether they were proportionate to the original codes or theme, and whether the contrast highlighted a clinically relevant matter in line with the research aims. If the oppositional codes were deemed to be relevant, then the researcher demoted the original

[21] See extended paper section 2.5 for further detail on each step of analysis

theme, and created a new theme to reflect the refuting collection of codes or themes[22]. This process was verified by the authors one and two. Given the first author's prior knowledge of the topic, it was deemed necessary to include this additional step to reduce potential researcher bias. Table 5 outlines each step of the analysis.

Table 5.

Thematic Analysis Steps adapted from Braun and Clarke (2006)

Step	Description
1. Familiarisation with the data	Read and re-reading, noting down initial ideas.
2. Coding the data	Firstly, search through data and identify meaningful units of text that fit the deductive coding framework. Secondly, inductively code interesting and relevant parts of the data systematically across the entire data set, collating data relevant to each code.
3. Searching for themes	Collate deductive and inductive codes into potential themes, gathering all data relevant to each.
4. Refutational stage	Check for contrasting themes across the data set or codes that refute current themes.
5. Reviewing themes	Check the themes work with both the coded extracts and the entire data set and generate a thematic map of the analysis.
6. Defining and naming themes	Ongoing analysis to refine each theme, and the overall narrative the analysis tells, generating clear definitions and names for each theme.
7. Producing the report	Select key extracts that represent the data and relate to the analysis of the research question and literature, producing a scholarly report of the analysis.

Researcher Reflexivity

The researcher is a trainee Clinical Psychologist with interest in endings, improving clinical practice within PD services and has recently published research in the area (see Webb, Schröder & Gresswell, 2018).

[22] See extended paper section 2.5.4 for a step by step example

Results

From the analysis, three themes and eleven sub-themes were identified; 'Loss' (loss of the therapeutic relationship, loss of the therapeutic environment, the role of previous losses); 'Responses to Loss'(numbness, anxiety/fear, anger, sadness and acceptance/hope); and, 'Boundaries' (boundaries in therapy, after therapy and the boundaries of time-limited therapy). A thematic map was developed to represent the key themes diagrammatically (see Figure 3); each theme is described and illustrated with excerpts below.

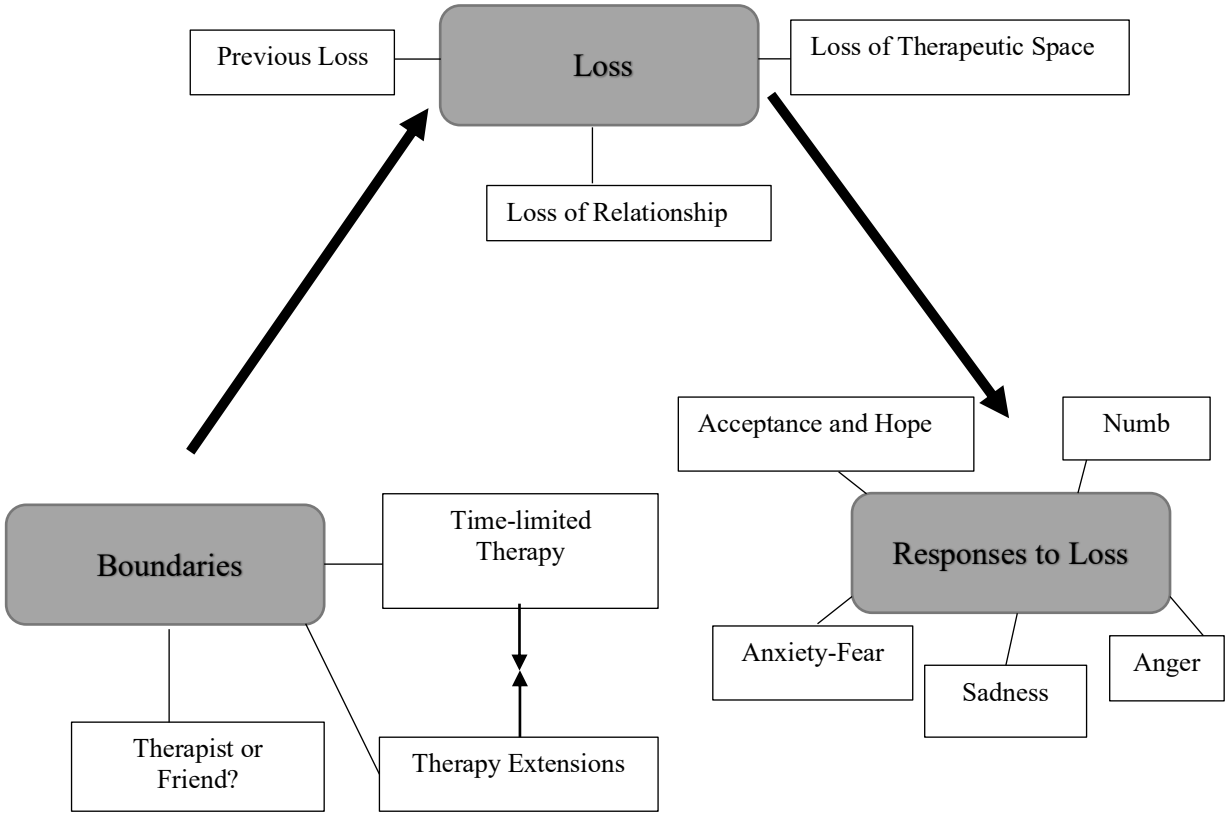

Figure 3. Thematic map of service users' experiences of ending

Loss

'Loss' was a prominent feature across all service users' experiences of ending. This theme captures the loss felt from ending the relationships formed within therapy, the loss experienced from no longer having access to the therapeutic space and the role of 'previous experiences of loss' in determining participant experiences.

'All or Nothing'- loss of the therapeutic relationship.

Most participants described experiencing a sense of loss around the ending of the therapeutic relationship and in particular, experienced loss coincided with the intensity of the relationship formed within therapy.

> "*I think it is just the fact that it was all or nothing. It was so intense when it happened, and it did me so much good then like.*" (Participant 2)
>
> "*Well to be honest with you, I did not like the thought of it because, I did think I would not have anyone else.*" (Participant 5)

Loss of the therapeutic space.

Some participants also experienced loss in relation to losing access to a regular therapeutic space. In particular, accessing group-therapy appeared to enable participants the opportunity to relate to others; which elicited a sense of belonging and offered comfort.

> "*Yes, it's like anything you go to something for a year you do get, it becomes your, your friend. And also, it was like a comfort blanket, it was in my comfort zone."* (Participant 6)
>
> "*To go and feel belonging in a group, but then it felt like it just stopped and now there is nothing and no one.*" (Participant 2)

The role of previous loss.

Participants indicated that their previous experiences of loss had provided an expectation and informed their current understanding and experience of ending therapy. As illustrated by one participant, "*I find all endings difficult.*"(Participant 1)

Others illustrated how from their previous experiences of loss they had developed negative expectations of others that functioned to shield them from any potentially undesirable consequences around the loss of therapy.

"*I'm not really bothered to be honest because I have lost a lot of people in my life and people come and go so, I just sort of think well you've been though worse.*"(Participant 6)

"*Well, I did miss it and I expected to be sadder than I was, but I think part of me has got used to losing friends due to the nature of my illness.*" (Participant 8)

Dynamic Range of Responses to Loss

This theme encapsulates the dynamic manner in which service users experienced a range of different emotional responses to loss. Service users' responses included feeling numb, anxiety and fear, anger, sadness and hope and acceptance. Responses were experienced both concurrently in no particular order and in parallel, overall creating a complex picture of service users' experiences of ending, as demonstrated by one participant:

"*I was really happy and really proud of myself but I also felt myself detach because I didn't want to feel sad but it was definitely emotionally draining. It took a lot out of me*."(Participant 8)

Fear.

Fear was the predominant emotional response experienced by participants ending therapy. Individuals' concerns related to two key areas; the fear of abandonment, and their fears related to the unknown entities of life beyond therapy.

For some participants, the ending of therapy evoked a fear of being left on their own and abandoned, as illustrated by one individual:

"*There was in as much as, nobody cares anymore and that I am on my own now and if anything happened to me nobody would know*" (Participant 1)

Other participants expressed fears around the lack of support beyond therapy.

"*Fear is the biggest emotion that I had leaving because I was just scared about what next*." (Participant 8)

Service users' fears centred around the ending point of therapy however anticipation anxiety was also expressed during the build up towards discharge, as demonstrated:

> "*No, I think my anticipation was worse, the leading up to it I was more, I had more anxiety but on the day I just accepted that it is happening.*" (Participant 6)
> "*I think at the time it did feel like urrr god… the ticking of time and the almost like, oh gosh like am I going to get everything in, can I get, whereas urm… and anxiety around the ending as well.*" (Participant 4).

Numb.

Feeling 'numb' towards the ending process was also described by some individuals as a way in which they coped with other related emotional states or directly with the ending of therapy.

> "*I think you just kind of go with it. I almost went into, I don't know, autopilot mode with it. But that was a good thing for me and I guess that was my way of coping with it*. " (Participant 2)
> "*I went a bit numb I think probably as a way to cope so I wouldn't get too upset.* (Participant 8)

Anger.

Some participants also reported episodes of anger in a direct response to the loss of therapy.

> "*Angry, angry that, I don't know, because it is hard, it's that all or nothing.*" (Participant 2)

However, for some individuals anger presented as a secondary emotion in response to the fear of abandonment.

"*Like they don't care or that you had wasted 12 months because now you're just going back to the life you had before*." (Participant 6).

One participant acted upon their anger and, "*walked out of the group and slammed the door really loudly.*"(Participant 3), but they did return to the group after a period of reflection.

Sadness.

Ending also evoked episodes of sadness for many service users, as illustrated by one individual:

"*A lot of us were that upset we were all supposed to go for a coffee afterwards but none of us ended up going because we were so upset.*" (Participant 2).

In particular, for two participants the ending evoked negative thoughts and hopelessness indicative of risk-related behaviours; however, these experiences were fleeting and occurred amongst a range of different emotional responses.

"*There were some thoughts which you would probably think were silly but I thought well this is the end and I have no future and then the suicidal thoughts came back.*" (Participant 1).

"*It would be easy just to revert back to the [negative] behaviour you have done for years and years.* "(Participant 6)

Hope and Acceptance.

The oscillation between different emotional states throughout the ending process seemed to conclude with participants reporting a sense of hope and acceptance around the ending of therapy.

"*It wasn't that it didn't come easy it was more, I was more sad but I was trying to keep positive and think, well it's the end of a chapter of you not being well and you have overcome that now, you are on the right meds, you have had the right therapy and move forward*." (Participant 6)

Boundaries

This final theme highlights the role of procedural and relational boundaries in determining service users' experiences of ending.

Boundaries imposed by time-limited therapy.

Through participant experiences it became evident that the procedural boundaries of NHS time-limited therapy had a role in setting the parameters that inherently determined service users' experiences of ending.

The session limitations imposed by the therapeutic or service models explicitly defined the end point of therapy, as explained, "*they very much make it time bound*" (Participant 4). The inherent constraints imposed by this method of therapy delivery seemingly reduced the emotional impact and offered a level of containment for service users.

> "*DBT from the second you start you know when it is you are going to end and although it makes it terrifying and a counting clock, it does make it feels like you're not being dropped, you're not being abandoned*." (Participant 7)

Therapist or friend?- boundaries in therapy.

Some participants reflected how different approaches to the therapeutic relationship impacted their experiences of ending.

Overall participants highlighted the importance of clear boundaries and a professional approach when developing trust in the therapeutic relationship.

"S*he [the therapist] was always friendly but she was very professional whereas my key worker I sometimes felt like she was being my chatty aunt which made it difficult to trust her with my responsibilities so, whereas my therapist was always very professional when she was talking about personal experiences in an example. She was always very much professional which really helped keep the border in mind*." (Participant 8).

"*I didn't know anything about her, actually that's quite good, quite weird but quite good*" (Participant 4)

When professional boundaries were upheld within a therapeutic relationship participants felt emotionally contained and the therapeutic relationship remained supportive.

"*If I had acted up in-front of her that I felt not okay, getting upset and crying because I was distressed, she would behave in a way that wasn't emotional so that the next time once I had calmed down I felt I could talk to her. It wasn't like any bridges were burnt because she hadn't gotten upset*." (participant 8)

"*she hadn't almost become a friend, she was my therapist*."(Participant 4)

In contrast, one participant reflected how their therapist's openness to share personal experiences led her to hold back when she most needed to seek support.

"*I imagine it is part of her job to relax me by talking about her own life but it often felt like it was making it harder to trust her because she became you know more of a person, rather than a professional doing her job. I didn't want to tell her when I was having problems of my own*." (Participant 8)

When asked about whether and how the therapeutic relationship with the therapist impacted their ending experience, participants reflected,

"[the therapist] kept up that professional wall so it was easier for me to become distant when she wasn't offering support anymore." (participant 8)

"*I didn't have to give anything back... with her it was a complete one-way process."(*Participant 4).

Therapy extensions.

Participants also provided examples where therapeutic contact was extended beyond the original boundaries set out in their therapy contract. For example, some

participants described how their therapists made contact within them after therapy ended.

> "*I don't really keep in touch with anybody except for this psychologist, because my dad passed away at the end of January and so she contacted me to say, if I needed extra support it is there, which I thought was really nice*."(Participant 6)

Another participant indicated how they were kept 'on the books' by the health professional involved for a significant period of time, despite not engaging in any specific therapeutic work.

> "*Well, I didn't like it but she basically she carried on as long as she could keeping me on the books but under the radar so to speak."* (Participant 4).

Through their experiences, participants indicated that extensions to therapy were instigated by the therapist. Extensions appeared to be offered in a way that felt less formal to service users. Therapist behaviours may be understood as an attachment response to the service users' expression of needs; however, extensions were seemingly not made explicit. One understanding may be that the decision to extend therapy was in part, about therapists managing their own emotional needs. This, in turn, impacted upon how service users experienced the ending of therapy and perhaps left them feeling a sense of responsibility towards the therapist experience of ending, as illustrated in one example:

> "*Well, one of the group facilitators I was quite close to her and in my last meeting with her, urrr... I think she found it difficult saying goodbye to me…she cried.*" (Participant 3).

Discussion

This research aimed to explore service users' experiences of endings from NHS community PD services. Semi-structured interviews were conducted with eight individuals discharged from services and three key themes were identified.

In line with Quintana's (1993) conceptualisation of ending, the findings from this research indicate that endings within therapy are experienced as a loss. Although Quintana's model (1993) reports two polarities 'ending as crisis' and 'ending as transformation', this research provides support for only the latter experience. The lack of a crisis is perhaps counterintuitive but consistent with the systemic review findings by Webb, Schröder & Gresswell (2018); which reports that service users experienced the ending as a process of independence and growth in nine out of the twelve papers reviewed. Arguably, the participants within the current study were a self-selected group, and therefore one consideration might be is that those individuals who experienced the ending as a crisis, perhaps as one might expect from individuals with a PD diagnosis, did not engage with the study.

Synthesised from the research findings, one way of explaining the lack of 'crisis' within service users' experiences could be that the boundaries attached to therapy offer containment around the emotional impact of the ending experience (through managing expectations), and in doing so, prevent a crisis from occurring. Further explained, from the research findings we can conclude that when therapy ends, the experienced sense of loss and subsequent responses to loss, are in part determined by the boundaries imposed on and within therapy (Figure 4). Firstly, the procedural boundaries outline the parameters of therapy (e.g. the number of sessions, the model of therapy, service procedures around discharge) and set expectations around 'when' and 'how' therapy will end. These processes enable service users to anticipate and prepare for the loss of therapy and effectively regulate their emotional response to the ending.

Secondly, relational boundaries operate within therapy. When relational boundaries are effectively managed, expectations of the therapeutic relationship, and how it will end are clear and predictable. This enables an individual to experience the emotional impact of ending therapy in a contained and supportive manner. When relational boundaries are not maintained, expectations are unclear, and the ending experience is not well-contained; this may provoke avoidable negative responses towards the ending. In instances where procedural boundaries are breeched it is

hypothesised that it is an attempt to restore emotional control within the therapeutic dyads.

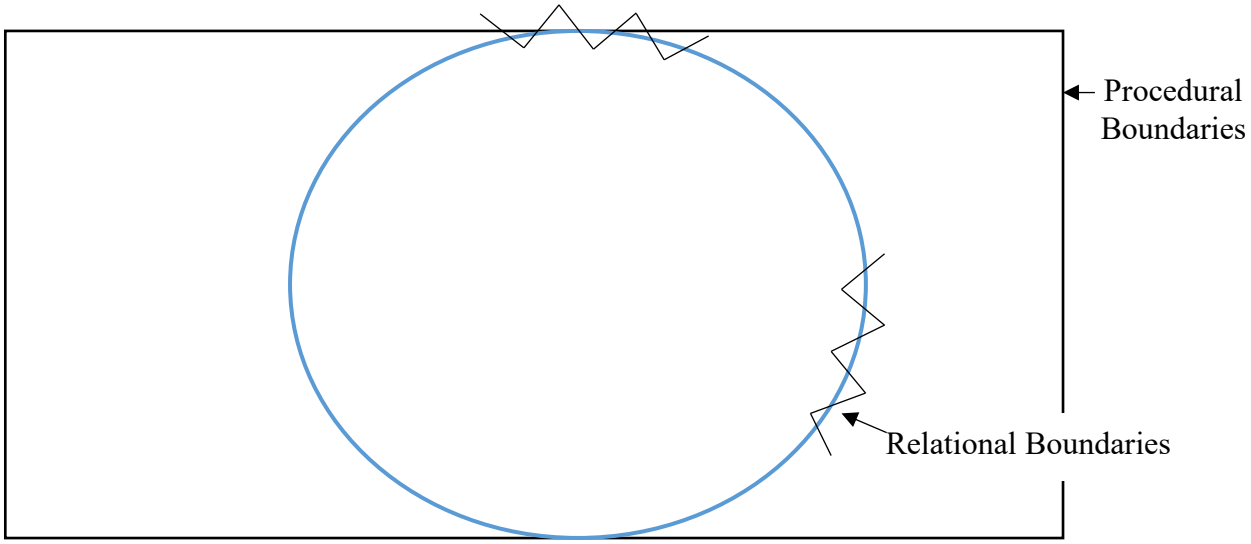

Figure 4. A model for understanding boundaries in service users experiences of ending.

The dynamic range of responses to loss and progressive movement between different emotional states reported from the current research findings indicate that endings are evocative, and that service users need time and support to process the emotions that arise. The patterns described are consistent with both Strobe & Schut, (1999) and Kubler-Ross (1973) who suggest that individuals' transition between different emotional states or stages until they reach a point of acceptance. Kubler-Ross's (1973) model is particularly relevant to this research because the range of responses to loss reported by participants(fear, numb, anger, sadness, hope and acceptance) mirror almost exactly the key stages of the Kubler-Ross model of loss (denial(fear and numb), anger, depression and acceptance). One conclusion is that perhaps this similarity adds confirmatory support that endings in therapeutic contexts are experienced as a loss as indicated from the research. One stage of the Kubler-Ross model (1973) missing from the current research is the stage of 'bargaining'. Accordingly, when loss is endured an individual may engage in a period of questioning in an attempt to negotiate and avoid grief. In the context of the current research findings, one possible explanation may be that the boundaries imposed by time-limited therapy remove the responsibility and ambiguity around the decision to end (Webb, Schröder & Gresswell, 2018), and therefore absolves the need for negotiation or 'bargaining'.

The phenomenon of 'boundaries' described here is currently not addressed within the existing literature on endings. Professional boundaries are considered integral to ethical clinical practice (Health and Care Professions Council [HCPC], 2016). However, evidence from this study highlights that boundaries may also have a strong clinical benefit specifically around the management of the ending. Within the literature, professional boundaries are considered important in the development of effective therapeutic relationships (Zur, 2009); however, we can conclude that boundaries also have a parallel role in determining how the ending of therapeutic relationships are experienced. From an attachment perspective, effective boundaries that are consistent and containing enable the therapeutic relationship to model a secure attachment so that when therapy ends, service users can transition the external experience of therapy into an internal representation (Bowlby, 1980), therefore containing the emotional distress in response to loss.

An attachment understanding of service users' experiences of ending is, however, contingent on a relationship forming in the first place. As highlighted by Holmes (2010), an individual can only be securely separated if they feel attached in the first place. Individuals whose early experiences involved unresponsive and unavailable caregiving develop negative expectations of others and therefore learn to expect rejection. By deactivating their distress responses and activating defences (Reisz, Duschinsky & Seigel, 2018) an individual is able to avoid the 'real relationship' of therapy and engage on a superficial level. When therapy ends, the separation is merely a detachment from something that never really was and so the impact of loss is not endured. Whether or not this is an adaptive or dysfunctional way of relating is debatable. Fraley and Shaver (1999) argue that detachment re-directs attention away from experiences that threaten an individual's ability to self-manage and effectively regulate their emotions and therefore serves as adaptive avoidance. However, given the relative important of therapeutic alliance in predicting positive outcomes (Norcross, Zimmerman, Greenberg & Swift, 2017), there are unlikely to be sufficient therapeutic gains if engagement is purely at a superficial level.

The two sub-themes 'therapist or friend?' and 'therapy extensions' infer that health professionals also struggle with the emotional impact of ending therapy.[23] The finding concurs with previous research (Boyer & Hoffman, 1993; Murdin, 2000) that reports that endings also provoke difficult emotions and a real sense of loss for the therapist. In particular, the findings suggest that boundary violations unhelpfully prolonged the process of separation and impacted upon therapists' affective reactions. As indicated by the literature, therapists are not immune to the emotional impact of loss and therefore repeatedly 'letting go' of therapeutic relationships (Murdin, 2000) is likely to influence how the therapist manages future therapeutic endings. Particularly when therapy is perceived as 'unsuccessful' (Schlesinger, 2005), a therapist may be negatively reinforced to violate boundaries as a means of preventing or tolerating therapeutic failure. Unclear or inconsistent boundaries may be particularly unhelpful for individuals with a PD diagnosis whose previous patterns of relating are typically more consistent with an insecure attachment style (Sharp & Fonagy, 2008).

To conclude, models for understanding boundaries in therapy[24] and strategies for effectively managing boundaries may also have a parallel role in directly supporting health professionals to manage their own experience of ending.

Clinical Recommendations

Drawing upon the research findings, we recommend the following to practitioners:

- Acknowledge with service users that endings are typically experienced as a loss and that support to manage the transition effectively can be offered as part of the ending process through reflection.
- Understand (or formulate) service users' experiences of endings in the context of their previous experiences of loss.
- Acknowledge that loss evokes a range of emotional responses that an individual can oscillate between; normalising this process may help to ameliorate the impact of ending.

[23] See extended paper section 4.1 for attachment understanding of therapist responses to ending
[24] See extended paper section 4.2 for an example

- Many therapeutic models (e.g. DBT; Linehan, 1993)[25] can and should be used to formulate and help support service users to identify and manage their emotional response to ending.
- Adhering to the procedural boundaries set by the service provider (e.g. set the number of sessions, length of therapy) and making this transparent is considered helpful. Firm and predictable external boundaries may prevent rumination and habitual unhelpful meaning-making around the client or the world being flawed.
- If it is necessary to extend therapy (alter the boundary), then this should be a deliberate act to address the service users' needs; the new end-point should be transparent and clear.
- Be a therapist, not a friend; use supervision to reflect on the therapeutic relationship and explore any challenges to maintaining boundaries
- Take time to reflect on the role of effective professional boundaries in the development and ending of relationships.
- Services should invest time in supporting staff to manage professional boundaries and endings (including their own) in therapy (e.g. through supervision or ending workshops).

Limitations and Future Research

One limitation of this study is that all interviews were conducted over the telephone; this would have likely limited the researcher's ability to pick up on subtle nuances and non-verbal cues that would have aided the research process. As an alternative, face to face interviews would have provided further contextual information that may have improved the quality of the data and engagement during the interview (Novick, 2008). Regardless, telephone interviews were chosen by participants. Considering the sample population, one speculation may be that telephone interviews provided a distance that enabled individuals to engage in the content of the research without having to engage in a 'real' researcher-participant relationship. Another

[25] See extended paper section 1.4.3.2

understanding would be that participants opted for telephone interviews due to not wanting to return to the service from which they had recently been discharged.

Another potential limitation is that the conclusions and clinical recommendations developed from the findings are informed by the researcher's subjective interpretations of eight participant's experiences. We acknowledge that the researcher's previous knowledge of the subject area may have influenced how the interpretation of the findings developed into recommendations. Although a descriptive presentation of the data would have sufficiently provided an understanding of participants' experiences of ending, Braun and Clarke (2018) encourage that data are interpreted further to tell an active story about the 'So What?' of the data. This process facilitates the transition of research evidence into applied clinical practice.

Future research should attempt to further understand the role of boundaries in the experiences of ending therapy. In particular, the relational boundaries within the therapeutic relationship were identified as an important part of service users' ending experience and therefore, would warrant further exploration. However, the research provides just one half of a perspective regarding the ending of the therapeutic relationship. Therapists' experiences of ending are entwined with the services users and therefore, future research should perhaps consider the ending experiences of therapeutic dyads. Certainly, Further exploration into therapist's challenges with endings could help improve the management of ending both for service users and therapists.

Finally, the researchers have provided a synthesis of the findings that proposes that boundaries have a role in determining service users' experiences of ending. Our conclusions were devised from a limited sample, and therefore we invite other researchers to explore and develop the model within the current or other populations.

Conclusion

This research concludes that endings are experienced as a loss and evoke a dynamic range of emotional responses. A synthesis of the research findings highlights the importance of boundaries in determining service users' experiences of endings.

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Extended Paper

Service Users' Experiences of Ending from Community Personality Disorder Services

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Overall Word Count: 30606 words

1.Extended Background

Within this section, further background information is provided to facilitate a deeper understanding of the phenomena of endings. A theoretical understanding of how endings are conceptualised is presented and critically discussed. Finally, a critical discussion on the current management of endings in clinical practice and an extended critique of the available empirical literature concludes this section. The aim is that further background information and critique will help contextualise the current research and highlight key points of discussion.

1.1 Rationale for Two Journal Papers

During the analysis, the key themes began to separate into two definitive categories; service users' personal experiences of the process of endings (paper one) and service users' responses and reactions ending (paper two). A decision was made that two journal papers would be written for publication with each focussed on their respective parts.

1.1.1 Journal paper.

Psychology and Psychotherapy Theory Research and Practice (PAPTRP) was considered a suitable target journal for both papers given the topic, qualitative methodology and target audience. The journal has previously published qualitative papers on endings, including the systematic literature review by Webb, Schröder and Gresswell (2018). The review summarises peer-reviewed published evidence on service users' experiences on endings and informs the deductive coding framework of the discussed research project. The journal also promotes the application of research into clinical practice by publishing articles with accompanying practitioner points. This appeals to the current research, which critiques the lack of clinical and management guidance on endings within clinical practice. PAPTRP has an impact factor of 2.097, which is comparable to other Clinical Psychology journals. Considering these points, PAPTRP was considered a suitable means of disseminating the current research project. Authors guidelines dictate that qualitative projects should be restricted to a maximum of

6000 words. Full authors guidelines are available from https://onlinelibrary.wiley.com/page/journal/20448341/homepage/forauthors.html

1.2 'Ending' Definition and Terminology

There exist numerous and continuing debates within the literature around what and how an ending should be defined and conceptualised. The current research adopts Gelso and Woodhouse's (2002) definition that describes the 'ending' of therapy as the "*last phase of counseling, during which the therapist and client consciously or unconsciously work toward bringing the treatment to an end*" (p.346).

This definition was chosen because the researcher felt that describing an ending as 'phase' rather than a definitive end-point (or discharge date) was more reflective of how endings occur in clinical practice. In particular, understanding an ending as 'phase' captures both the procedural aspects of endings but also the indefinites and nuances around ending therapy. Further to this, Gelso and Woodhouse's definition acknowledges ending as a collaborative process which highlights the dyadic nature of ending relationships in therapy and reflects the wider literature that considers both service user and therapists experiences of endings. A final point is that the selected definition does not align with any particular theoretical position or model, it therefore adopts a neutral stance on what an ending is; this reflects the researchers own curiosity of what and how an ending should be conceptualised when beginning this research journey.

'Ending' was chosen as the preferred terminology to describe the phenomenon of study, as it was considered by the researchers to be more universally understood without further explanation, and it is not associated with any particular theoretical approach. As a critical realist, the research aimed to draw on numerous theoretical approaches to develop an understanding of the findings; it was therefore deemed necessary that terminology remains neutral. 'Termination' is an alternative term used within the literature; however, the phrase is almost always associated with psychoanalytic perspectives and has often been criticised for its negative associations with terminations of pregnancy (Pedder, 1988). 'Discharge' is another term used within the literature; however, it is more often than not associated with service-led processes

rather than service user experiences (Bryan, 2010). Furthermore, being discharged from a service subtly suggests that an individual is 'done too' rather than 'done with'; ironically, this contradicts the current NICE guidelines (2009) around how endings should be approached. In summary, 'ending' will be the primary term of reference used within the current research; however, termination will be used when discussing the psychoanalytic literature.

1.3 Conceptualising an Ending

Within service delivery, an ending can often be pinpointed to a specific discharge date, however, within the literature and clinical practice an ending is conceptualised as a 'phase' that represents the final stage of the therapy process (Gelso & Woodhouse, 2002). The specifics around when a service user progresses into the final phase are often not explicit; however, it estimated that the ending phase accounts for approximately 10-25% of the entire therapy (Gelso & Woodhouse, 2002).

In clinical practice the ending phase of therapy is considered complete when an individual is discharged from the service, however, theoretical perspectives highlight that endings are not so 'absolute' and are a more complex than initially assumed.

A review of available literature conducted by the researcher indicated that Attachment theory (Bowlby, 1980) and Freudian psychoanalytic theory (1937) were the two most commonly cited perspectives for understanding endings within clinical practice; how each conceptualises the ending will, therefore, be discussed within the following sections.

1.3.1 Freudian perspectives of termination.

Freud is considered one of the earliest theorists to reflect upon the termination of therapy through his references to a failed termination in the case of 'Anna O'(Freud & Breuer, 1895), a premature ending in the case of 'Dora' (Freud, 1905) and an overdue ending in the 'Wolf-Man' case (Freud, 1918). Within these cases Freud discusses the role of transference and countertransference relative to the ending of therapy. At first, Freud concludes that transference is a complication of therapy that should be avoided through the termination of analysis (in the case of 'Anna O'), however, he later reverts

that transference cannot be evaded. Reflecting upon the case of Dora (1905) Freud concludes that the resolution of transference is key when determining when analysis should terminate.

Surprisingly, Freud does not acknowledge or discuss transference within the case of the 'Wolfman' (Freud, 1918) despite the patient reporting concerns about their relationship (Wolfman, 1971). One speculation is that Freud was 'stuck' within a countertransference himself which hindered his ability to reflect on the case and resolve transferences before termination. The lack of resolution may explain why both Freud and 'Wolf-Man' were still engaged with one another beyond therapy (for examples, see Kupers, 1988). Interestingly, Freud did not mention termination within the 'Wolf-Man case '(1918): this can perhaps be inferred as an unconscious acknowledgement that the termination proposed was not absolute.

Although undoubtedly aware of the implications of un-worked-through termination, neither Freud nor his followers gave much attention to the terminal phase of therapy beyond this period until two years before Freud's death (Novick, 1999). It was at this point in 1937 that 'Analysis Terminable and Interminable' was written. Within 'Analysis Terminable and Interminable' Freud reflects upon terminations within his early case studies to question and stimulate debate around whether or not there is '*such a thing as a natural end to an analysis'* (p.219) (Freud, 1937). He does not give a conclusive answer to his question but does stipulate that the ending of analysis should occur when: 1) the individual is no longer experiencing symptoms; 2) there is an indication that symptoms will not reappear beyond therapy, and 3) the individual is unlikely to experience any further change as a result of remaining in therapy.

A review of the termination literature in psychoanalysis (Firestein, 2001) highlights how there is disagreement within the field around 'when' and 'how' analysis should end. Freud's conceptualisation of when an ending should occur is not dissimilar to many current service delivery models that use 'symptom-reduction' as a criterion for evaluating therapeutic success (e.g. Improving Access to Psychological Therapies [IAPT]). The success of therapy is, however, not solely determined by symptom reduction; other factors have been used to indicate the ending of therapy. For example,

Freud's two subsequent criteria around when to terminate relate to the longevity of therapeutic success over time which he refers to as contingent on the resolution of the transference neurosis' (Freud, 1914). In summary, temporary gains can be achieved simply through being in therapy in the presence of a therapist; however, further analysis around internal conflicts and the individual's ability to resolve conflicts independent of the therapist is necessary for lasting gains.

Although Freud stipulates several criteria for when a natural ending should occur, he also uses his points to thoroughly debate whether a natural end point is even possible. Drawing upon the 'death instinct'[26] (Freud, 1920), Freud explains how even when a natural end point is reached, analysis will remain incomplete ('interminable') because there will always remain parts of the psyche unanalysed; it therefore becomes impossible to meet all three criteria that Freud originally proposed. The contradictions within Freud's account highlight the complexities of termination but also the uncertainly within the field around how termination is conceptualised, and therefore how and whether ending of analysis is determined.

1.3.1.1 *Critique of Freudian understandings of termination.*

Despite being considered an important phase of the therapeutic process (Gelso & Woodhouse, 2002) historically, termination was not formally acknowledged within the literature until the publication of 'Analysis Terminable and Interminable' (Freud, 1937). One possible explanation for the lack of attention to the topic may be as a result of psychoanalytic perspectives at the time, which viewed termination as indistinguishable from the rest of the analysis and therefore insignificant (Knafo, 2018). What we know now from the literature is that termination in therapy can also evoke difficult emotions for the therapist (Boyer & Hoffman,1993; Murdin, 2000). One suggestion may be that the association of termination to endings with other more personal endings and indeed the 'ultimate ending' (Freud, 1920) may have led psychoanalysts at the time to unconsciously or perhaps consciously ignore or deny acknowledgement of the topic. Interestingly, the topic of termination did not come to fruition until Freud was facing his

[26] In 'Beyond the Pleasure Principle' Freud (1920) proposed that "the goal of all life is death" and defines this concept as the 'death instinct'.

impending death. One speculation could be that Freud's attention to the topic was in some way self-acknowledging; certainly, throughout 'analysis terminable and interminable', he makes consistent references to the ultimate or 'finite ending'.

1.3.2 Attachment perspectives on ending.[27]

In contrast to psychoanalytic perspectives, attachment theory assumes that the therapeutic setting provides a secure base and real-relationship from which exploration and relearning patterns of relating can occur (Bowlby, 1980). The therapeutic relationship is considered a model for other relationships (Holmes, 1996), and therefore when therapy ends, the service user may experience a real sense of loss, which then triggers attachment responses.

Attachment views on endings in therapy align with the 'transformation' model proposed by Quintana (1993). From this perspective, endings are conceptualised as a loss, but are also understood as providing an opportunity for growth and transformation. Charman and Graham (2004) describe this transition as a 'weaning' process, which may help the therapist understand how they might engage with service users in the process of ending. From an attachment perspective (Bowlby,1980; Holmes, 1997) a successful ending is determined by whether or not an individual can engage in the process of internalisation. Further explained, the process of internalization requires the service user to transform the real-relationship with the therapist and characteristics of therapy into an internal representation that can then be accessed when required after therapy ends (Schafer, 1968).

1.3.2.1 Critique of attachment perspectives on ending.

Criticisms of attachment theory relate to the construct of the 'real' relationship that is pertinent to therapy. Given that endings in therapy involve the service user and therapist going their separate ways, the topic and related critiques are considered relevant background knowledge for understanding the phenomenon.

[27] See paper 2 for further discussion

Although attachment theorists claim the therapeutic relationship is 'real' (Bowlby, 1980; Holmes, 1997), it might be argued that the therapeutic setting is artificial and does not mimic the full intricacies of a personal relationship. Consequently, for some individuals, this could mean that generalising learning beyond the therapeutic context may be difficult. Therapeutic success in attachment is measured by whether or not an individual internalised the real relationship; however, one criticism is that by enacting a real relationship the service user may also suffer the loss experienced when that therapy ends.

A further consideration is that by engaging the inescapable 'real relationship', the service user may also be vulnerable if a therapist intentionally or unintentionally reinforces previously held negative internal working models (Bartholomew & Horowitz, 1991).

1.4 Management of Endings in Clinical Practice

To further contextualise the findings of this study, an overview is provided around how endings are currently managed in practice.

1.4.1 Service-level management of endings.

The over-arching organisational structure and commissioning of a service dictate the availability, length of time, input and type of support an individual may receive. The ending point is consequently pre-determined and therefore managed by the limits imposed by service delivery factors.

Recent austerity measures have resulted in NHS services becoming under increasing pressure to improve their productivity and efficiency as care providers (Kinman and McDowall, 2016). In response, organisations are changing, and new service pathways have been implemented to offer brief psychological therapies that offer a limited number of sessions (IAPT, 2008). The initiative aimed to increase access to psychological therapies to more individuals nationally and has managed this with some success (Parry et al., 2011); plans are now in motion to deliver this commitment on a local level (NHS, 2019).

Assuming service users move through the service consistently, discharges from the service will also increase; this may create potential concerns around the management of endings in clinical practice. Further explained, health professionals are transitioning towards a different way of working that requires them to work more concisely yet competently within set time-frames (e.g. 12 sessions). The changes may lead professionals to compromise on interpersonal aspects of care in order to meet the demands of the service. For example, expecting therapists to develop and end therapeutic relationships within a restricted time limit may put increasing pressure on the therapist to work in a way that is unfamiliar to them and their profession. The inherent pressures of working in this way may impact how the therapist then manages the ending. This discussion highlights an important paradox between therapists perhaps wanting to be caring, supporting and reflective practitioners while also seeking to meet the demands of the service.

One alternative consideration may be that the limited time available to develop a relationship may make endings easier and more manageable for the therapy dyad as both parties will have had limited time to form an emotional connection. A further advantage may be that having external factors dictate the endings rather than it being the therapist choice may reduce the perceived responsibility towards the ending and reduce ambiguity around the decision to end (Webb, Schröder & Gresswell, 2018).

In summary, the prominence of prescribed session lengths and policies dictating the parameters of service provision, are likely to have an impact on how endings are managed by professionals and consequently how service users experience endings. Certainly, if service throughput and discharge data are to be used for monitoring, commissioning and as key performance indicators (KPI), then services would benefit from attending to the process and management of discharge.

1.4.1.1 Mann-time limited therapy.

NHS delivery of care commonly utilises fixed time-frames to denote when therapy should end. However, despite the relative importance of ‘time’, there is little

reflection on how models of service delivery impact individual experiences of the ending. Likewise, the majority of therapy approaches do not give adequate attention to the ending phase of therapy[28]. One known psychological approach that does explicitly acknowledge the ending of therapy is Mann's (1973) time-limited therapy. Within his 12-session time-limited therapy model (1973) Mann highlights how the ending of therapy is a destabilising experience that erupts unavoidable feelings of loss, abandonment and separation. Mann considers endings to be the central issue of therapy and advocates that individuals should reflect on their internalised experiences of endings; how they are enacted and subsequently how they are processed in relation to the ending of therapy. Through processes of 'separation-individuation' Mann (1957) encourages mastery over separation, and the management of ending becomes a crucial and thoughtout part of treatment.

1.4.2 NICE guidelines.

According to the NICE guidelines (2009) (1.1.7) health professionals and those involved in supporting endings should:

> Anticipate that withdrawal and ending of treatments or services, and transition from one service to another, may evoke strong emotions and reactions in people with borderline personality disorder. Ensure that:
>
> - Such changes are discussed carefully beforehand with the person (and their family or carers if appropriate) and are structured and phased
>
> - The care plan supports effective collaboration with other care providers during endings and transitions, and includes the opportunity to access services in times of crisis

[28] See section 1.4.3

- When referring a person for assessment in other services (including for psychological treatment), they are supported during the referral period and arrangements for support are agreed beforehand with them.

Considering the relative importance of endings within the theoretical literature and available empirical evidence, it is surprising how little has been written by NICE (2009) to support practitioners in managing endings effectively.

1.4.2.1 Critique of current NICE guidelines for managing endings in PD.

The NICE guidelines are limited in instruction and based on findings from a multi-method service evaluation (Crawford et al., 2007) where management of endings was not the primary focus of the evaluation. Interviews were conducted with current and past service users from 11 different pilot sites and reported service users' concerns around the preparation, management and impact of ending therapy. One fundamental limitation of this evaluation was that participating services had limited experience of discharge and therefore, a majority of interview data focused on service users' anxieties around their prospective ending rather than their actual ending. In common with the NICE guidelines, recent guidelines for working with offenders with PD (NOMS & NHS England, 2015) highlighted the need to be mindful of the endings and the risk of destabilisation at this stage. Explicit planning of the ending of contact and a gradual reduction in the frequency of contact is advised.

1.4.2.2 Implementation issues with NICE guidelines.

Despite NICE (2009) offering recommendations on the management on endings, the implementation of guidelines generally continues to be a much-debated topic (Ament et al., 2015). On the one hand the NICE recommendations provide a point of reference for health professionals that may help guide their clinical practice according to evidence-based practice. From an alternative viewpoint, NICE guidelines are criticised for creating an "unhelpful illusion of neatness" (Court, Cooke Schrivener, Wells & Wells, 2017) that inhibits flexible service delivery and indirectly hinder patient experience and choice. Having guidelines to refer to may be particularly important for staff working within PD services, who report experiencing particular anxieties around

supporting individuals with a PD diagnosis, more so than in other populations (Crawford, Adedeji, Price & Rutter, 2010). Staff concerns relate to the increased levels of risk that are commonly perceived to be associated with individuals with a PD diagnosis (The National Institute for Mental Health in England [NIMHE], 2003).

1.4.2.1 Alternatives recommendations.

Bonsmann and Gubi (2017) have also provided guidelines to support health professionals in managing endings in clinical practice. Similar to the current study findings, Bonsmann and Gubi (2017) encourage practitioners to acknowledge the ending with the service user. However, the recommendations provided are specific to managing premature endings and therefore, not comparable to the recommendations of the current study. Interestingly, one of the recommendations suggested that therapists should allow 'an open door' for clients to return. This suggestion directly contrasts the findings of the current study that concludes that procedural boundaries should be clearly defined. If empirical research into ending continues to provide recommendations for practice, there may be value in conducting a review of recommendations and developing a consensus around how endings should be managed.

1.4.3 Models of therapy.

The strategies for managing endings in clinical practice are also informed by the evidence-based approaches that are used within services. Some approaches are embedded within the model of the service (e.g. IAPT); pathways of care are determined by diagnoses and therapy duration is guided by NICE recommendations (e.g. Cognitive Behavioural Therapy [CBT], Beck, Shaw, Rush and Emery, 1979). Other approaches are determined by the evidence base for the service user group (e.g. Dialectic Behavioural Therapy) (Linehan, 1993) or are employed flexibly dependent upon service user needs and therapist preferences. The key principles of each approach determine the length of therapy and therefore dictate when therapy is expected to end.

Two approaches in particular, are deemed worthy of further discussion. Firstly, CBT is the most common approach recommended and used within psychological therapies; therefore it is necessary to obtain an understanding of endings in clinical practice from this perspective. Secondly, Dialectic Behavioral Therapy [DBT] (Linehan,

1993) was specifically developed for use with individuals with PD and is considered an effective treatment approach within this population.

1.4.3.1 CBT

According to Beck et al., (1979) endings within CBT do not pose as many problems as they may do in longer-term therapy because the CBT approach is time-limited. The stance taken by Beck et al. (1979) directly opposes the views of Mann (1979) who states that termination is the central issue for therapy, regardless of the length of time spent in therapy. Within the literature there is limited empirical evidence to support either argument; however, attrition and re-referral rates observed within short-term therapies (Cairns, 2014) could suggest that endings (in the absolute sense of the term) are more problematic than initially expected. Despite initial claims, Beck et al., (1979) do acknowledge that effectively managed endings will help maintain therapeutic gains.

Within CBT, the overarching focus of therapy is symptom reduction. Throughout therapy, individuals are encouraged to apply cognitive and behavioural strategies and become their own therapist. The emphasis upon the educational aspects of treatment and the promotion of independence are claimed to diminish issues around ending therapy (Beck et al., 1979). From a CBT perspective, therapists can encourage independence by supporting the individual to challenge unhelpful cognitions of self-doubt (Nelson & Politano, 1993). In turn, service users will be able to self-manage any problems that may arise from the ending of therapy.

1.4.3.2 DBT

In contrast to the traditional CBT perspective from which DBT originates, Linehan (1993) states that endings can be extremely difficult.

Within DBT, an ending is not considered to be an absolute rupture of the therapeutic relationship; instead the service user transitions from being a ‘patient’ to being an ‘ex-patient’. Linehan (1993) consummates this point by recommending that staff should walk each service user to the door; Linehan claims that this conveys an intended message that they will meet again soon. This perspective conceptualises

ending as an 'interrupt' from therapy and acknowledges that individuals may require further input from services; repeated service use is a common occurrence amongst individuals with a PD diagnosis (Bryne, Henagulph, McIvor, Ramsey & Carson, 2014). One speculation is that adopting this alternate perspective on endings, albeit implicit, may support the transition from 'patient' to 'ex-patient' with increasing permanency. Further explained, operating an 'open door' policy may reduce the expectations upheld by service users around their ability to maintain therapeutic gains beyond therapy.

Comparable to the findings of paper one, Linehan (1993) recommends that endings are discussed from the beginning and throughout therapy. Linehan (1993) also advises that endings should be 'tapering off': she encourages therapists to express confidence in the service user's ability to manage independently beyond therapy. Collectively the recommendations indicate that endings should be managed reflectively and mimic the current guidelines proposed by NICE (2009).

1.4.4 Direct management of endings.

Within the UK National Health Service (NHS) the processes for ending are typically depicted by the service provider, however, at a face to face level endings are managed by the health professional and the individual in receipt of a service.

However, according to Novick (1997), the management of endings in clinical practice is often considered a 'blind spot' for therapists (Novick, 1997) who seemingly struggle to address the topic with service users. For example, some therapists are reported to actively avoid negotiations around the ending until the last session (Bostic, Shadid & Blotcky, 1996). One possible way of understanding therapist avoidance behaviours may be through the behavioural principles of operant conditioning (Skinner, 1963). Further explained, endings are also reported to evoke difficult emotions in a therapist (Bonsmann & Gubi, 2017; Murdin, 2000): these negative consequences of ending may act an aversion for future discussions around the topic. Through repetition, the therapist is reinforced to avoid the feared-stimulus (discussing the ending). Therapists' emotional and behavioural responses to ending therapy and the challenges that endings entail, may also be understood relationally as expected responses to a difficult, but typical human experience of ending a relationship.

1.5 Personality Disorder and Endings

According to The Diagnostic and Statistical Manual of Mental Disorders (DSM-V) (American Psychiatric Association, 2013), a PD defined as:

> '*enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time and leads to distress or impairment.'*

Endings are considered to be particularly difficult experiences for individuals with a diagnosis of PD (Bateman & Fonagy, 2000). One understanding is that the ending triggers the individual's attachment systems and prompts disruptive emotional and behavioural response (Holmes, 2010)[29].

Other than the current study, there exist no other qualitative studies that specifically explore service users' experiences and responses to an ending from a PD service. There is, however, a plethora of research that provides a clear indication that premature endings are prolific within PD populations (Chiesa, Drahorad & Longo, 2000; Kroger, Roepke & Kliem, 2014; Ogrodniczuk et al., 2008); and significantly more prevalent than in non-PD populations (Kelly et al., 1992). Research by Martino, Menchetti and Beradi (2012) reported a high drop-rate of 51.2 %, although this is considered to be at the upper range, other studies do report higher than average attrition rates (Kroger, Roepke & Kliem, 2014). The observed rates of premature endings prevalent within PD services have considerable associated service costs (Sampson, James, Huband, Geelan & McMurran, 2014) and, therefore, interventions for managing ending within PD services are becoming increasingly important.

[29] See paper two for discussion

1.6 Empirical Research on Endings

1.6.1 Theory-research gap.

Despite considerable theoretical discussion on the topic, there remains a dearth of empirical research on endings. Gelso and Woodhouse (2002) suggest that one possible reason for the deficit can be attributed to '*the great complexity of termination,*'(p345). Certainly within the literature, the varying conceptualisations of endings and debates around 'when' and 'how' an ending should occur highlight the complexities of ending. The phenomenon of endings is further complicated by numerous intra and interpersonal factors that are said to influence how endings are experienced (O'Donohue & Cucciare, 2008; Schlesinger, 2005). According to Freud (1937) an ending in therapy is a temporal representation of the 'finite' ending that is death (Freud, 1920). Using the 'death' connotation to understand the apparent theory-research gap, it perhaps could be hypothesised that exploring the topic theoretically is perhaps less 'finite', and psychologically safer, than conducting evidence-based research. As noted by Gelso and Woodhouse (2002) conducting research on endings can be 'emotionally conflictual' (p345), this may in part explain why researchers in the field initially opted to explore the procedures involved in ending rather than the experiences.

1.6.2 Process of ending.

Attempts at understanding the procedures or tasks that occur during the ending phase of therapy are highlighted within two key studies; namely Marx & Gelso, (1987) and Quintana and Holahan, (1992). Marx and Gelso (1987) used survey-style questionnaires with service users at a university counselling centre to identify the key tasks involved in the process of ending. Qunitana and Holahan (1992) asked counsellors to report on the processes of ending that occurred with one 'successful' and one 'unsuccessful' case. Both studies reported that endings were discussed and that both the therapist and service user engaged in a range of activities. Gelso and Woodhouse (2002) produced a table comparing the results of the two studies which showed considerable similarities (correlation 0.90, Quintana & Holahan 1992) between service users and therapists' accounts about what transpires during the ending process.

In summary, both service users and therapists reported that the following processes occur when ending therapy:

- The process for ending is mutually decided
- An ending date is set
- Therapy is summarised
- Goals of therapy are reviewed
- The client's future plans are discussed
- The therapist provides an open invitation back to therapy
- The therapist provides advice on future support
- The service user thanks the therapist
- Both share feelings around the ending of therapy
- Both engage in a parting gesture (e.g. shaking hands)

Although the two studies indicate what occurs during the ending phase of therapy, the quantitative methodology may have limited the data collection process. Further explained, participants were asked to tick whether or not a process occurred, and therefore, the method did not enable researchers to extrapolate inductive or more in-depth information on the tasks involved in ending.

This restrictive binary approach towards creating a list of activities of the processes involved in ending seems disproportionate to the rich theoretical discussions that preceded and instigated the research. One speculation is that the complexity of endings has perhaps led researchers to conduct research tentatively, in an attempt to first understand what is happening before delving into more profound understandings. The use of quantitative methods in the research of ending processes may be considered a safe way of exploring such a sensitive topic. It perhaps enables the researcher to remain distant from the process; in theory, 'if you are not involved you cannot experience'. However, this has ultimately resulted in a somewhat guarded and superficial summary of the process of ending, meaning the current understanding is limited.

In contrast, with qualitative methodologies, the researcher becomes more involved in the process, and the method evokes deeper thinking around the topic, meaning and interpretations and reflections which in itself can be draining.

1.6.3 Responses to ending.

Early psychoanalytic perspectives on ending therapy typically adopted the 'endings as loss' model (Quintana, 1993) and as a result, endings were, and still are, primarily viewed as a painful and negative experience that encompasses loss and mourning (Kauff, 1977); however, this overtly negative perspective is not universally accepted. Many psychoanalysts (e.g. Malan, 1979; Quintana, 1993) and models of psychotherapy (e.g. Acceptance and Commitment Therapy [ACT], Hayes & Smith, 2005) acknowledge the normality of loss and expect that endings will evoke feelings of sadness or emotional pain. Their portrayal of endings is generally considered to be more balanced by also reflecting accompanying positive responses to loss.

The available empirical evidence tends to support the latter perspective, reporting how service users experience a wide range of both positive and negative responses when ending therapy. Negative responses (e.g. anger, sadness, guilt) relate to unresolved interpersonal issues (Råbu & Haavind, 2018), the loss of a meaningful relationship (Baum, 2005), perceived lack of readiness to end (Perren, Godfrey & Rowland, 2009) and dissatisfaction with their therapy (Roe, Dekel, Harel, Fennig & Fenngi, 2006) or therapist (Bonsmann, 2017). Positive responses (pride, joy, relief) have been connected to the independence gained from ending therapy (Fortune et al.,1992), having a positive therapeutic alliance (Knox, Adrians, Everson, Hess, Hill & Crook-Lyon, 2011) and positive therapeutic gains (Roe et al., 2006). Positive feelings around endings are reported to be marginally more prevalent than negative responses or defences (Roe et al., 2006; Quintana & Holahan, 1992).

The literature indicates the range of responses experienced by service users ending therapy; however, there are several contextual factors that may restrict the generalisation of findings to current UK NHS practices[30]

[30] Methodological limitations are discussed within paper 1 and in extended paper section 4.4

Firstly, the dearth of the empirical literature on the topic is highlighted in a systematic literature review by Webb, Schröder & Gresswell (2018) which identified only twelve peer-reviewed journal papers that qualitatively explored service users' experiences of endings from a mental health service or psychological therapy. Of the papers reviewed, only four studies were identified from the UK. Two of these studies (Madders & George, 2014; Tetley, Evershed & Krishnan, 2011) explored service users' experiences of transitions from high-secure environments: the conclusions drawn from the findings are representative of these specific settings. The other two studies conducted within the UK (Bonsmann & Gubi, 2017; Etherington & Bridges, 2011) and the remaining non-UK studies (Cuddeback, Shattell, Bartlett, Yoselle & Brown, 2013; Knox et al., 2011; Olivera, Braun, Penedo & Roussos, 2013; Råbu, Binder & Havvind, 2013; Råbu & Haavind, 2018; Roe, Dekel, Harel & Fennig, 2006a; Roe et al., 2006b; Scamardo, Bobele & Biever, 2004) explored service users' experiences of endings from a private-practice setting.

Unlike the NHS model of service delivery, endings from private practice are not restricted by any system or service led protocols. The decision to end is instead entirely determined by either the therapist or the service user. One key point of discussion is that endings in private practice are not subjected to the NHS 'Payment by Results' (PbR) initiative (Department of Health, 2012) which provides incentives for services to work within a framework of 'episodes of care' (NHS England & NHS Improvement, 2016). This model of the delivery of care intentionally applies a time-limit on therapy and subsequently determines when therapy will end from the start. In contrast, within private practice the decision to end is negotiable and influenced by many varying contextual and therapeutic variables (Roe et al., 2006b). One notable point of similarity is that private practice clinicians are typically paid per session although in private settings this is not predetermined; arguably the therapist's decision to end therapy may therefore be influenced by the associated cost implications. This point highlights potential ethical concerns around 'when to end' therapy in private practice which is beyond the scope of this thesis, however, it highlights a reoccurring issue that endings are a complex phenomenon.

As discussed within the review (Webb, Schröder & Gresswell, 2018), the time-limited restraints of NHS care perhaps remove ambiguity around the decision to end: arguably this will impact how a service user then experiences the ending. As demonstrated within the current study, the findings suggest that procedural boundaries of NHS time-limited therapy set the parameters (or expectations) of therapy which inherently determined service users' experiences of ending. Given the differences between NHS delivered care and private practice, the results and conclusions from the wider empirical literature on endings should be considered but with these limitations in mind.

2. Extended Methodology

Within this extended methodology section the researcher's epistemological position is discussed and rationales are provided for varying methodological decisions. Ethical considerations and quality assurance procedures will conclude this section.

2.1 Epistemology

Guba and Lincoln (1994) define a research paradigm as, "the basic belief system or worldview that guides the investigator, not only in choices of method but in ontological and epistemologically fundamental ways" (p105). Accordingly, each paradigm adopts a different set of related assumptions around the form and nature of reality (ontological question), how the researcher relates with what can be known (epistemological position), and how the researcher goes about their inquiries (methodology). Acknowledging and declaring the researcher's epistemological position is considered an important process in guiding the research design, methodology and interpretation of findings (Braun & Clarke, 2013).

These researchers have approached this study from a critical realist position. Critical realism developed as a result of the ongoing debate between the positivist and constructivist paradigms (Denzil & Lincoln, 2011) and adopts elements of both to inform its unique ontological and epistemological position. Critical realism asserts that a reality exists, however, it is not limited to our knowledge of reality (epistemological

position). Instead, critical realism states that what is possible to know is only a small accessible part of a much deeper reality (Fletcher, 2016).

Critical realists posit that pre-existing knowledge or theory may exist before empirical research; however, a caveat is held that what is 'known' already may not be a true or entire reflection a reality (Bhaskar, 1979). The current project was informed by previous research on endings conducted by the researchers (Webb, Schröder & Gresswell, 2018) and so pre-existing knowledge of the topic is recognised. In accordance with the critical realist position, existing understandings of endings are incorporated into the project through a deductive process of analysis; however, these initial ideas are considered a starting point whereby throughout the process of analysis each deductive idea was either supported, expanded or dismissed. To facilitate a more accurate understanding of reality, the research also included an inductive process which enabled new information to emerge from the data. The hybrid steps described were encompassed within a thematic analysis approach. Thematic analysis does not align to any particular epistemological position (Braun & Clarke, 2006) and so can be approached from a critical realist perspective.

Similar to other critical realists, the researcher's view is that further knowledge can be gained through applying theory to explain social phenomena, as this in turn can help us to get closer to reality (Danermark et al., 2002). In keeping with the researcher's epistemological position, during the analysis and discussion of the research findings, psychological theories have been utilised to make sense of the research findings and explain causal relationships between different phenomena within service users' experiences of endings. Adopting an explanatory approach to analysis is consistent with the critical realist position (Fletcher, 2016) and also with the researcher's personal views around why and how research should be conducted. The researcher's perspective is that research should be purposeful and aim to expand or generate new knowledge that can then be applied into clinical practice. Research should therefore be conducted in a manner that seeks to inform practice; a critical realist approach to analysis would facilitate this process.

2.2 Methodology Rationales

2.2.1 Rationale for qualitative approach.

Qualitative approaches to research are concerned with understanding and interpreting an individual's lived experiences in naturalistic settings (Elliot et al., 1999) to assess how individuals 'make sense of the world' (Willig, 2001). Qualitative methodologies are considered to be compatible with post-positivist approaches and enable exploration of individual experiences in context to explain the reality that is the phenomenon of study. The current research aimed to explore and extrapolate meaning from service users' subjective experiences of endings and therefore a qualitative methodology was particularly suited to answering the research question.

A further rationale is that the majority of empirical literature on endings focusses on quantitative approaches to understand service users' experiences of ending. Although the literature outlines a basic description around what happens during the ending phase of therapy (see section 1.6.2), it provides little understanding around service users' subjective experiences. Arguably, ending experiences are a qualitative phenomenon and therefore are best understood through qualitative methods. Furthermore, adopting a qualitative approach would begin to address these particular gaps within the literature.

2.2.2 Rationale for research interviews.

Within qualitative methods, interviews are considered the 'gold standard' in methodological validity and rigor (Novick, 2008) and are commonly used alongside a thematic analysis approach (Braun and Clarke, 2006). Semi-structured interviews were deemed the most appropriate method of data collection for exploring service users' experiences of endings within the current research. Conducting semi-structured interviews enabled the researcher to delve deeper into the participants' experiences and to follow-up on relevant topics of interest through open questioning. As highlighted by Braun & Clarke (2014), these avenues of discussion may not have been explored through a structured interview or questionnaire.

2.2.3 Alternative group approach- focus groups.

Focus groups would have provided an alternative forum for exploring service users' experiences of endings, however, the geographic spread of the recruitment sites and the anticipated low participant numbers meant the method was not considered a viable option. The group setting of a focus group may have had several advantages particularly in facilitating topics of the discuss that were either unexpected or aroused debated (Acocella, 2011). A focus group may have facilitated a deeper exploration of service users' experiences; however, one potential limitation is that individual narratives can sometimes become lost within the group setting (Smithson, 2007), particularly if certain participants are more forthcoming than others. Arguably the 'group' is the unit of analysis within a focus group (Smithson, 2007), yet given the diversity within the sample (e.g. services, therapeutic models, modes of intervention) the group perspective would unlikely capture the breadth and depth of experiences obtained through individual interviews.

2.2.4 Rationale for mode of interview delivery.

Participants were given the option to take part in the interview either face to face or via the telephone. All eight participants opted for telephone interviews. The two modes of interview were offered in an attempt to eliminate any barriers related to recruitment and promote participant inclusion.

2.2.5 Rationale for thematic analysis.

Braun and Clarke (2006) define thematic analysis as a qualitative methodology for systematically identifying, organizing and offering insight into patterns of meaning across a data set. Through a staged process, thematic analysis enables themes to emerge that are considered important to the description of the topic being discussed (Fereday & Muir-Cochrane, 2006) and typically relate to a specific research question (Daly et al., 1997). A theme is defined as a 'specific pattern of meaning found within the data' (Joffe, 2012) that derives from interpretations of observable and latent content (codes) (Joffe & Yardley, 2004). Swain (2018) defines a code as a word, phrase or sentence that relates to the phenomenon of interest.

The researchers selected thematic analysis (TA) as the preferred qualitative methodology for the following key reasons;

- TA was considered suitable for answering the research question
- TA fits with the critical realist epistemological position of the research
- TA offers a structured approach to analysis
- TA is flexible and accommodates the hybrid deductive-inductive approach

Further discussion around each rational and an overall critique of TA is provided below.

2.2.5.1 Answering the research question. The research aimed to explore service users' subjective experiences of endings. TA is used to understand meaning and experiences and was therefore deemed an appropriate methodology.

2.2.5.2 Fitting the epistemological position. TA does not align to any particular epistemological position (Boyatzis, 1998) and so is considered a suitable method consistent with the critical realist epistemological position of the researcher. The epistemological flexibility that TA affords, means research can be approached and conducted in a variety of different ways.

2.2.5.3 TA offers a structured approach. There is an abundance of literature that focusses on the underpinning epistemological assumptions, design and different methods of data collection within quantitative approaches (Alasuutari, Bickman & Brannen, 2009). In contrast, the available guidance on how qualitative research should be conducted is limited, vague and overly complex (Braun & Clarke, 2013). Thematic analysis, in accordance with Braun and Clarke's six step method (2006), addresses these concerns by offering a systematic method for extrapolating codes from the data-set while also capturing the latent meaning of the data. Developed meanings (themes) that can then be related to wider theoretical concepts and back to the research question. The transparency of each step of the analysis process provides an opportunity for ensuring the credibility and overall trustworthiness of the research (Guba & Lincoln, 1985) (see extended paper section 2.7).

2.2.5.4 TA is a flexible approach. Following critical realism assumptions, the researcher aimed to develop an understanding of the meaning and experiences of participants through deductive (theory-driven) and inductive (date-driven) processes. Unlike other qualitative methods (e.g. Interpretative Phenomenological Analysis (IPA) ; Smith & Osborn, 2003) and Grounded Theory; Tweed & Charmaz, 2012) the flexibility of TA enables both deductive and inductive approaches to be used together as part of a structured approach (Braun & Clarke, 2013). Using a hybrid deductive-inductive approach enables research findings to be contextualised into the 'real world' (Javadi & Zarea, 2016). As TA is the mechanism facilitating this process, it would therefore be considered consistent with the aims of the researcher's beliefs around conducting research that informs clinical practice.

2.2.5.5 Criticisms of TA. There were several potential limitations and criticisms identified during the process of assessing the suitability of TA as a qualitative methodology for approaching the research inquiry.

There is considerable debate within the literature around whether or not TA is considered a method in its own right. Braun and Clarke (2006) argue that TA is an independent method that historically has been 'poorly branded' or disguised as another form of analysis (e.g. content analysis, discourse analysis) or has just not been acknowledged at all (Braun & Wilkinson, 2003). In an attempt to demarcate TA, Braun and Clarke (2006) provided explicit guidance on how to conduct TA through a six-step process of analysis. Since this development, there has been exponential growth in the use of the TA across a broad range of disciplines and it has become recognised as a method in its own right (Nowell, Norris, White & Moules, 2017); as well as being integrated within other approaches (Brooks, McCluskey,Turley & King, 2015). It is also argued that TA lacks integrity as a method in its own right, and instead is considered a generic skill used across qualitative research (Holloway & Todres, 2003). Clarke and Braun (2018) have since provided a critical reflection of TA and offered further justification for TA as a distinct analytical method.

One particular critique of TA is that 'thematic coding' is a common technique used across other methodologies (e.g. grounded theory) (Ryan & Bernard, 2000) and is not unique to TA. Arguably, however, this critique can also be applied to other qualitative techniques which often share common procedures (Bryman & Burgess, 1994). What differentiates TA from other methods is the flexibility in which the process of thematic coding can be conducted from a range of different approaches and underlying epistemological positions. Inevitably this has resulted in numerous variations of how TA is presented within the literature which has led academics to criticise the credibility and dependability of TA (Denzil, 2009). In such instances, it has often been the case that the researchers have typically not been explicit about their assumptions and the processes involved in analysis. Being transparent is claimed to enhance methodological integrity (Levitt, Motulsky, Wertz, Morrow & Ponterotto, 2017) and reduce general concerns around the trustworthiness of qualitative research (Guba & Lincoln, 1985). Within the current research, the researcher has considered transparency throughout by defining the epistemological position of the research (see section 2.7), rationale for the research methodology (see section 2.2) and each step of analysis (see section 2.5). Furthermore, Braun and Clarke's (2006) guidelines for doing 'good thematic analysis' and other worked examples (e.g. Fereday & Muir-Cochrane, 2006; Maguire & Delahunt, 2017) were used throughout to guide and appraise the research process.

2.2.6 Rationale for deductive-inductive approach.

In accordance with a critical realist epistemology, the researcher acknowledges that pre-existing research and theoretical knowledge on the topic of endings provides a partial understanding of what can be known. Although prior knowledge is not assumed to be an absolute truth (Bhaskar, 1979) it is acknowledged that it may in some way influence how data is collected, interpreted and analysed. Rather than attempting to bracket this prior knowledge, the researcher takes a position that it is best to embrace what is known through deductive reasoning. Yet, the researcher also acknowledged that any knowledge acquired so far is only part of a much deeper reality (Fletcher, 2016) and therefore an inductive approach for also gathering new information was also incorporated into analysis. A hybrid deductive-inductive approach (Fereday & Muir-

Cochrane, 2006) was considered an appropriate approach that incorporated both theory-driven and data-driven knowledge. The former deductive process involved pre-empirical codes derived from the literature on endings (Webb, Schröder & Gresswell, 2018) whereas the latter inductive process involved the induction of post-empirical codes that derived from the analysis of the data (Boyatzis, 1998).

2.2.7 Rationale for refutational stage of analysis.

An additional refutational stage was incorporated into Braun and Clarke's (2006) six step method of thematic analysis and was used within the current study to analyse the data. The inclusion of the additional step aimed to reduce potential researcher bias and improve the credibility of the findings by including a search for oppositional evidence. Acknowledging refuting participant experiences offered further assurances that the researcher was adopting a balanced perspective when reviewing the codes and themes. The additional stage also enabled conflicting topics to emerge and be acknowledged within the analysis (see section 2.5.4 for an example). Braun and Clarke (2006) encourage researchers to acknowledge inconsistencies within and across the data set; however, to our knowledge there has been no formal acknowledgement of a 'refutational' stage, therefore this method of analysis is considered unique to this research.

2.2.8 Alternative Approaches to TA.

During the development of the research several other methods were considered. The two main alternative approaches are discussed below and the rationale for why TA was preferred is outlined.

2.2.8.1 Interpretative phenomenological analysis.

IPA (Smith & Osborn, 2003) was considered as an alternative methodology during the design of the research. Similar to TA, IPA guides the researcher to make sense of the participant's experiences through their interpretations and therefore adopts an interpretive ontological stance (Smith, Flowers & Larkin, 2009). Although IPA has a focus on participant experiences, the approach adopts a 'bottom-up' or inductive approach to analysis and therefore does not take account of pre-existing knowledge in

the manner that deductive processes of TA would. Adopting an IPA approach would therefore reflect an inconsistency between the research design and analytical methodology (Brooks, McCluskey, Turley & King, 2015).

IPA is typically used with small homogenous groups as this enables the researcher to uncover as much as there is to know about the participant experiences in detail (Smith, Flowers & Larkin, 2009). Although the researchers of the current study expected low participant numbers (see section 2.3.7), participants were recruited across different Trusts from services that offered a range of therapeutic interventions and therefore the researcher did not expect a homogenous group. On this basis, TA was chosen as the preferred approach as it has been used consistently with heterogenous groups (Fugard & Potts, 2015).

2.2.8.2 Grounded theory. Grounded theory was also considered as an alternative qualitative approach. There are different versions of grounded theory (Tweed & Charmaz, 2012); that span a range of epistemological perspectives including the critical realist position of this research. Common to all grounded theory techniques is the inductive development of a theory from the data (Tweed & Charmaz, 2012), however, it was not the intention of the researchers to develop a new theory and so this approach was not selected. In addition, a grounded theory approach is not compatible with the deductive intentions of the researchers, who acknowledge the pre-existing literature on the topic.

2.3 Procedures for Identifying and Recruiting Participants

The process for identifying and recruiting participants is summarised in Figure 5.

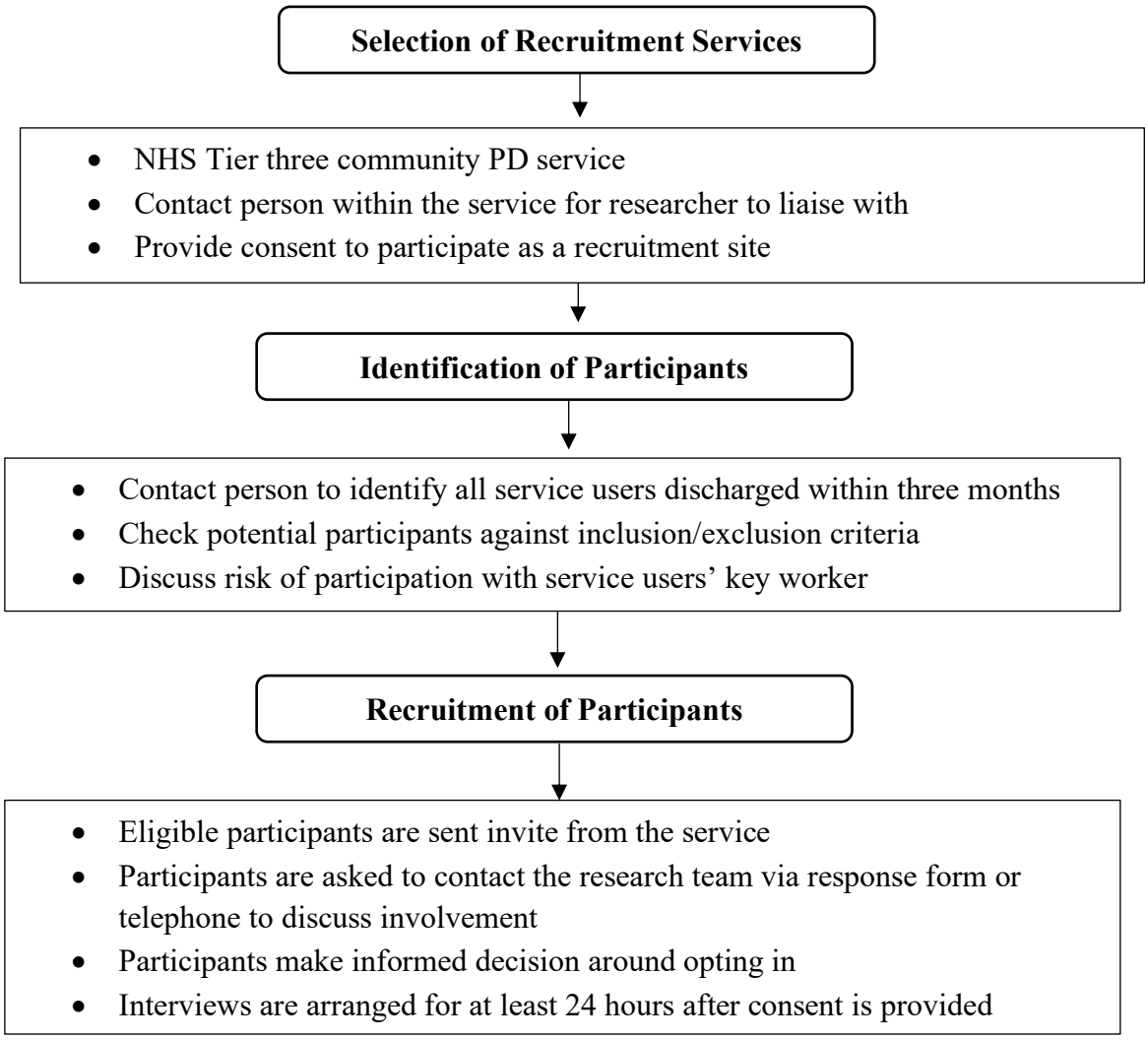

Figure 5. Identification and recruitment procedures

2.3.1 Selection of recruitment sites.

Participants were recruited from NHS services that: 1) identified as an NHS tier-three[31] community PD service; 2) could provide a contact person with whom the researcher could liaise with; and 3) provide consent to take part in the research as a recruitment site. Services were identified through NHS Trust websites and service leads were contacted initially via telephone informally and then by email formally to invite the service to act as a recruitment site (see Appendix A).

[31] The tiering system is a framework used to define the different levels of support available to meet the health and social care needs of individuals with PD and was originally developed by the NHS Health Advisory Service (2005) for use within Child and Adolescent Mental Health Services.

2.3.2 Identification of participants.

In accordance with Data Protection Act (2008) and NHS Information Governance guidelines (Department of Health, 2007) the identified research sites were required to identify and make initial contact with participants on behalf of the researchers. To aid this process, a contact person was identified in each service and the researcher liaised with them throughout. Each contact person was required to be: 1) a permanent NHS health professional working within the service; 2) understand and adhere to information governance procedures; and, 3) be available during the research time-frame to aid recruitment. Within all four recruitment services, the contact person was a qualified psychologist, or an assistant psychologist with a qualified psychologist supervising their involvement.

2.3.3 Procedure.

The identified contact person was required to identify all service users that had been discharged in the last three months regardless of whether they experienced a planned (in collaboration with the service provider) or unplanned ending (unknown to the service provider). Each individual was then reviewed by the contact person against the inclusion and exclusion criteria to assess their eligibility. For the exclusion criteria, the contact person was encouraged to discuss the potential risk of participating with each potential participant's key worker. The inclusion and exclusion criteria and rationale for each point are outlined in Table 6.

Table 6

Inclusion and Exclusion Criteria and Rationale

Criteria	Rationale
Discharged within the last three months	Three months is considered an appropriate time scale as it is recent enough to allow for reasonable recall of the ending of therapy
Aged over 18 years	Part of the service requirements and typical for NHS community PD services.
Be able to provide informed consent	To ensure the individual has capacity to make a decision around their involvement in the research
Be able to understand and speak English	To be able to understand research materials and participate in the interview process. The researcher was unable to facilitate the use of translators.
Excluded if the service felt involvement in the research would pose a significant risk for the individual.	To reduce potential negative impact of research involvement.

2.3.4 Recruitment of participants.

Eligible participants were sent a research invitation pack from the service that included a letter inviting them to consider participation (Appendix C) and a participant information sheet (Appendix D). Participants were asked to read the information carefully, discuss it with others if desired and, if interested, to contact the research team to discuss the research further. Interested participants were then asked to complete and return a response form (Appendix E) and consent form (Appendix F) if they were happy to continue. Participants were contacted within two weeks from receiving the response form to provide participants the opportunity to discuss the research and confirm their

understanding and consent. Arrangements for the research interviews were made during the discussion, however, the researcher ensured a 24-hour grace period was provided to enable participants to further consider their decision to be involved. Participants were reminded of their right to withdraw at this stage. In order to adequately describe the sample and to discuss any contextual factors that may arise, participants were asked to complete a demographic information sheet (Appendix G) at the start of the interview.

Participants were not specifically asked whether or not they had a PD diagnosis, nor was it a prerequisite for inclusion in the study for the following reasons. Firstly, the referral criteria for each of the recruitment services included individuals who had 'symptoms of a PD' and did not stipulate that diagnosis was an essential inclusion criteria for support. In accordance with the service position it was therefore deemed unnecessary to understand whether or not participants had a diagnosis because they already met the service criteria. Secondly, although PD diagnoses are defined into different categories according to the DSM-V, each have general transdiagnostic symptoms (e.g. interpersonal functioning, impulse control, affectivity, difficulties with perceiving self, others and the world) which may have contributed towards inconsistencies in inter-rater reliability and resulted in diagnostic reliability controversies within the literature (Chmielewski, Clark, Bagby & Watson, 2015).

Similarly, individuals with a PD diagnosis may also have other co-morbidities with common symptoms (e.g. depression, PTSD). A study by Lenzenweger, Lane, Loranger and Kessler (2007) reported how 85% of individuals diagnosed with BPD also met the criteria for at least one other personality disorder or mood disorder. Considering these factors, it would be difficult to definitively compare across PD diagnoses' should the researchers had recruited enough participants for this to have been an option. Further to this the researcher felt that asking about diagnosis was adjunct to the aims of the research which aimed to explore personal experiences.

2.3.5 Sampling.

In contrast to quantitative research, qualitative research methods do not adopt rigid sampling procedures. Therefore, within this research a non-randomised sampling method was used. Further explained, the invited participants all had particular characteristics that were set by the inclusion and exclusion criteria of the research.

Purposive sampling ensured that the sample was of interest to the research and was purposeful in addressing the research aims, whilst criteria were defined *a priori* and initial sampling and invitation to participate were based upon specific criteria, participants were then recruited on a voluntary basis to form the final sample.

2.3.6 Rationale for target recruitment sites.

Recruitment of participants targeted tier three NHS community PD services. Such services provide exclusive and specialist support to individuals with PD and are considered the largest providers nationally of community PD services (Crawford et al., 2007). The selection of tier three NHS PD services provided assurance that the processes for recruitment would be comparable across each site and managed through one single point of contact within the service. Alternative avenues were considered (e.g. community mental health teams [CMHT]), however, the service pathways, provision and processes often varied between services which meant processes for recruitment would have been less standardised, more complex and time-consuming. Despite logistical considerations, recruitment from NHS community PD services best-fit the client group the research sought to recruit.

Participants were recruited from four different PD services. Each service offered a range of structured interventions and support to help individuals manage their relationships, functioning and social needs. The researchers hoped that recruiting from multiple sites would capture a broader range of participant experiences of endings, that were not clouded by local service issues.

2.3.7 Rationale for sample size.

There are no specific guidelines around preferred sample sizes for research utilising TA (Guest, Bunce & Johnson, 2006), however, a study published within the target journal that adopted a TA approach reported recruiting eight participants (Small, Pistrang, Huddy & Williams, 2018). The figures are in line with Kruger and Casey's (2014) recommendation which suggests 6-12 participants is the ideal target sample size when conducting qualitative interviews.

To assess whether the agreed sample size was obtainable, it was firstly necessary to estimate discharges per service and then calculate an expected response rate. Discharge figures were available from one of the recruitment services and provided an estimate of the number of individuals discharged from the service per year. The annual review for the service reported that forty-four individuals were discharged during the previous year. From this figure, the researchers estimated that 14 participants would be discharged per quarter (or three-month period), per service.

2.3.8 Estimated response rate.

The number of individuals expected to respond to the research invitation was difficult to estimate for several reasons. Firstly, there is a paucity of qualitative research around service users' experiences of endings and no available data from which an estimate could be taken. Secondly, the research aimed to recruit individuals that had been discharged from a service with no future planned contact, rather than those who were actively engaged with the service with ongoing contact. The desired sample therefore restricted the recruitment method to one contact via the service, leaving no scope for follows ups or any direct contact with an individual. Several discussions with clinicians and researchers within the field indicated that they would typically expect a 1 in 8 response rate for generic research interviews but stated that they would expect the ratio to be greater for individuals discharged from a PD service. Using the approximate figure for number of discharges (14 individuals per 3 months) and the generic response rate (1 in 8) the researcher estimated that 5 participants would be respond to the invite.

To maximise opportunities for obtaining the targeted sample size an additional site was included (see Appendix O) at a later date. Contingency sites were subject to the same criteria and procedures as all other sites. A second wave of recruitment was also planned within one service if required (see Appendix N), however, this process was not necessary.

2.4 Development of Research Materials

This section provides further details around the development of the interview schedule (see Appendix B) and deductive coding framework (see Appendix H) used within the data collection and analysis.

2.4.1 Interview schedule development.

The interview schedule (see Appendix B) was based on the aims of the research and used as a guide for more exploratory discussion. In accordance with a critical realist epistemological position pre-existing knowledge on endings and gaps within the literature implicitly informed the development of the schedule. However, as encouraged by Glaser (1998) open-ended questions were used throughout to facilitate engagement and foster participant exploration of the topic. Once generated, questions were discussed within the research team, reflected upon, tested with other colleagues and revised accordingly. Given the researcher's previous knowledge of the topic, caution was taken to ensure questions were not loaded in any direction. For example, participants were asked neutrally positioned questions such as 'what, if anything made it easier or harder to end?' Participants were not asked about their reasons for entering therapy as it was not relevant to the research aim.

2.4.2 Development of deductive coding framework.

As part of the research process a coding framework was developed as a template for guiding the deductive part of the analysis (Crabtree & Miller, 1999). Literature on the topic is limited and so the deductive coding framework was informed by two existing sources. Firstly, the NICE guidelines (2009) inform how endings should be managed within community PD services and therefore give some indication on how an ending may be experienced as a recipient of NICE-delivered care. The guidelines were reviewed and coded line-by-line (Charmaz, 2006) and codes were extracted and included within the template (see Appendix H). Secondly, to acknowledge what is already known about service users' subjective experiences of endings, deductive codes were devised from the only known systematic literature review on the topic by Webb, Schröder and Gresswell (2018). Other sources may have unknowingly influenced the researcher's views and expectations of the data; however, no other sources were explicitly utilised for the deductive analysis. As recommended by Boyatzis (1998), the process of extracting codes for the deductive coding framework was reviewed within supervision. Codes were discussed with the co-researchers, amended (if necessary) and a consensus was reached. To ensure deductive codes were representative, the exact wording from the original source material was used (Fereday & Muir-Cochrane ,2016).

2.5 Analysis Procedure

Interviews were transcribed by the first author and analysed using a deductive-inductive hybrid approach adapted from the thematic analysis framework of Braun and Clarke (2006) (see section 2.2.6 for rationale). Transparency and replicability are considered important process for ensuring data is credible (Nowell, Norris, White & Moules, 2017) therefore, each step of the analysis is detailed below and supported with appended transcript extracts (see Appendix P).

2.5.1 Step 1-Familiarise yourself with the data.

The interview transcripts were read and re-read by the first author to ensure familiarity. During this process initial notes and ideas were documented within the researcher's diary and reflected upon and discussed within supervision.

2.5.2 Step 2-Coding of the data.

Given the hybrid approach to the research, data were coded in two ways, deductively (top-down) and then inductively (bottom-up). Each transcript was coded deductively before being coded inductively

2.5.2.1 Deductive coding of the data.

Using the deductive template of codes (see Appendix H), the first author initially searched through the data line by line to identify meaningful units of texts that fitted the deductive coding framework. Once identified, the units of text were annotated in green and labelled using the representative deductive code (see Appendix P). If a unit of text was identified as representing a deductive code but provided a little more information, the text was annotated in the same way but marked in orange to signify potential inductive data.

2.5.2.2 Inductive coding of the data.

For the second stage of data coding, the first author systematically coded line by line parts of the transcript that were interesting new avenues not previous highlighted through deductive analysis and were considered relevant to the research question (see

Appendix P). The researcher ensured that the codes generated represented the data as closely as possible: again this was reviewed within supervision.

2.5.3 Step 3- Searching for themes.

An excel spreadsheet was generated to record, organise codes, and link codes into themes. Firstly, codes from each transcript were transferred into the spreadsheet. Secondly, codes were then organised into categories of similar or related codes. This process required several revisions until gradually, initial sub-themes and themes began to emerge (see Appendix Q). Throughout this process, the original transcripts were checked periodically to ensure the developing themes were representative of the data set.

2.5.4 Step 4- Refutational stage.

Whilst identifying and organising codes into themes, initial ideas became apparent and were considered when subsequent codes were reviewed. Arguably, there is a potential bias within this process in that the researchers may have attended to information that is supportive or confirmatory evidence for the initial ideas. To address these potential biases, the process for analysis included a 'refutational stage' which was considered an attempt to balance out any potential bias through actively searching for conflicting evidence and acknowledging refuting participant experiences. As this stage is not explicitly included in Braun and Clarke's original paper (2006) but it was thought to have utility for this analysis, an example is provided below to outline the process and demonstrate instances where refutational searches were important.

1) During the organisation of codes, related codes were collated.

D7- ending was collaborative (T4, L269)
D7-Ending was discussed and planned with the SU (T1, L106)
D7-SU and therapist drew conclusions of therapy together (T4, L94)

An initial category of 'endings were done collaboratively' was created.

2) Other sets of related codes were organised into categories which included;

‘The ending was structured and paced’

‘The ending was discussed and planned’

‘Options after therapy were discussed’

‘Transition was supported’

3) Collectively the different categories were instrumented together as representing the theme ‘endings experienced in the context of reflective practice’.
4) The process of ‘searching for a theme’ involved several revisions, and therefore, the idea that different categories of codes represented ‘ending experiences in the context of reflective practice’ will have been acknowledged implicitly within earlier steps and influenced the further organisation of codes.

5) The researcher then searched for codes that conflicted or opposed either the categories of codes or the theme ‘endings in the context of reflective practice’. During this process, several codes were discovered that conflicted the previously developed categories.

D7-SU did not feel involved in the process of ending (T1, L279)

D29-Lack of involvement in the ending process (T2, L30)

D3-SU could not get hold of therapist around the ending time (T5, L19)

6) The refuting codes indicated that in some cases the ending experiences were not in the context of reflective practice. In response, the researcher demoted the original theme (experiences in the context of reflective practice) into a sub-theme that directly contrasted the second sub-theme ‘endings experiences in the context of reactive practice’. The overarching theme, ‘participant experiences in the context of reflective versus reactive practice’ was developed to capture the contrast between the two sub-themes.

2.5.5 Step 5- Reviewing themes.

The researcher reviewed each developing theme against codes and extracts to ensure each reflected the raw data in context. To aid this process, coded extracts for each theme were collated within the excel sheet to enable the researcher to look across the data set (see Appendix R). This was a recursive process whereby codes and themes were reviewed and re-allocated or re-defined; if they no longer worked with the original data then they were discarded. The researcher also mapped out the key themes and sub-themes diagrammatically: this allowed themes to be reviewed separately but also in connection to one another (see Appendix S). Several themes were amalgamated or separated over several revisions of the map to ensure the set of themes were distinguished from one another and coherent with the coded extracts. The researcher then re-read all the transcripts to consider whether the themes meaningfully captured participants' experiences of endings; further revisions were made if necessary, following the previous steps. The processes described above reflect the guidance provided by Braun and Clarke (2006) around ensuring themes are clear and distinguishable from one another.

2.5.6 Step 6- Defining and naming themes.

The researcher aimed to capture the essence of the theme by writing out a description for each theme that captured the focus, scope and purpose of each (see Appendix R). The naming of themes was checked against the data set, discussed in supervision and externally validated with doctoral colleagues. Extracts were then selected from across the data set that captured both the essence of the theme and illustrated the analytical and interpretative processes.

2.5.7 Step 7- Producing the report.

Throughout the analysis it became clear that there were two overarching themes; each had a different focus and independently took a different slant on 'service users experiences of endings'. To sufficiently report the sub-themes within each theme, the researcher wrote two papers. Within each journal paper, themes were described and supported with extracts to provide a narrative of service users' experiences of ending. The key findings were discussed separately from the results to avoid repetition. Critical

discussions were conducted in relation to the research question, and the empirical and theoretical literature.

2.6 Ethical Approval and Considerations

Ethical approval was obtained from the University of Lincoln School of Psychology Research Ethics Committee (SOPREC) (REF: PSY1617140) (Appendix J) and from the Leeds NHS Research Ethics Committee (REC (17/YH/0221) (Appendix K). Local NHS Trust approvals were also obtained from each of the recruitment sites. This research was conducted according to the British Psychological Society's (2014) code of human research ethics and UK Policy the Framework for Health and Social Care Research (2018). The following ethical issues were considered.

2.6.1 Informed consent.

Participants were sent a participant information sheet (Appendix D) from their respective service provider containing information about the study. Participants were then invited to contact the research team or fill in the response form (Appendix E) if they would like further information or wished to be contacted by the researcher to discuss the project further. This initial telephone contact aimed to answer any questions participants may have about the project and provide clarity about what the interview would involve. The intent of the study, participant involvement and participant rights were thoroughly explained to ensure participants were informed. If participants wished to opt into the project, they were asked to read and complete a consent form (Appendix F) and return it to the research team. If participants decided that they did not want to participate, their information was destroyed immediately via confidential waste. Interviews were arranged at a time suitable for the participant. A 24-hour period was allowed between giving consent and the interview taking place to ensure the participant had time to reflect on their decision and withdraw if desired.

2.6.1.1 Capacity to consent. In accordance with the Mental Capacity Act (MCA) (2005), the researcher considered each participant's capacity to consent and take part in

the study at each contact. Although capacity was not formally assessed[32], informally the researcher determined through discussion the participant's ability to understand and weigh up the benefits and costs of participation by going through the information sheet and consent form. If a participant were to lose capacity during the interview process, the interview would be stopped but information collected so far would be retained and used in the analysis. This is on the basis that when the information was provided, the participant had capacity to consent. This process was agreed with the participant at the time of consent. The researcher had completed training on the MCA as part of their NHS employment.

2.6.2 Right to withdraw.

Participants were reminded at each telephone contact that their participation was voluntary. Participants were also reminded of their right to withdraw from the study at any point up until two weeks after the interview took place, at which point the response form (Appendix E) containing personal information would be destroyed via confidential waste. Participants' right to withdraw was also included within the participant information sheet (Appendix D) and consent form (Appendix F).

2.6.3 Confidentiality and data protection.

Participant confidentiality and anonymity were maintained throughout the project by ensuring any identifiable personal information was managed professionally, lawfully and in a secure manner. To maintain anonymity, each participant's data were allocated a pseudonym to protect their identity. Participant data were stored on a password protected USB drive, accessible only to the research team. Transcripts were anonymised and any information that may identify a participant or the service they attended was removed. Excerpts and quotations were also selected carefully to ensure that they did not contain information that would result in the participant or service being easily identified.

[32] There were no participants that met the MCA stage 1 requirement [presence of mental disturbance] so there was no reason to proceed to stage 2 [formal assessment of ability to understand, weigh up information and retain].

In accordance with Information Governance (IG) (Department of Health, 2007) and the Data Protection Act (1998), participants were identified and screened against the inclusion criteria by a contact person within the recruitment service. Eligible participants were sent a study information pack from the service and invited to opt in. This process was necessary because it would have been unlawful for the research team to have accessed participant information or to make contact with participants without their prior consent. This process of recruitment was thoroughly discussed and received a favourable REC opinion.

Participant data were stored on a password-protected computer file on an encrypted memory stick accessible to the research team only. Consent forms were stored separately in a locked filing cabinet at the University of Lincoln (and will be moved into the University archive service upon project closure). In accordance with University of Lincoln research storage policy, all data related to the project will be stored for seven years. Participants were informed via the participant information sheet, consent form and verbally upon each telephone contact that their information would be treated confidentially and were informed how information would be securely stored.

During the research write-up stage, the EU General Data Protection Regulation (GDPR) (2018) and UK Data Protection Act (2018) were published. Both policies replaced the existing Data Protection Act (1998). The HRA GDPR guidance[33] was consulted on whether, and how, the new regulations should be addressed within the discussed project. The HRA state that the GDPR regulations are only applicable to data collected after the 25th May 2018 and therefore no further action regarding GDPR was necessary for this project.

2.6.4 Risks for participants.

The research team recognised that discussing 'endings' may be a sensitive topic for some individuals and could be a potential source of distress. Several steps were taken in order to minimise any distress caused. Firstly, a contact person (see section 2.3.1.2 for criteria) within each recruitment service was assigned to identify eligible

[33] https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/data-protection-and-information-governance/gdpr-guidance/

participants and exclude anyone, who in their clinical opinion (or through discussion with a key worker), was considered at significant risk of experiencing emotional harm as a result of participating in the research. The contact person was encouraged to discuss any uncertainties within supervision.

Participants were informed that their involvement may cause distress in both the participant information sheet and during verbal conversations. To manage distress during the interview, agreements were made beforehand on how the participant and researcher could break or terminate the interview if they felt it was necessary. At the end of the interview, participants were offered the opportunity to reflect on the interview process and debrief. Participants were also provided details of local support services at the end of the interview and within the participant debrief sheet (see Appendix I).

2.6.5 Potential risks for researcher. The project was not anticipated to pose any known risks to the researcher involved. However, the vicarious impact of hearing participants discuss potentially emotive and sensitive topics may have resonated with the researcher. Reflective discussions during supervision occurred to discuss and process any issues.

2.7 Quality Assurance

As qualitative research becomes increasingly acknowledged as a valued methodology, there are increasing demands for it to be conducted in a manner that assures the process and outcomes are both valid and reliable. There is a lack of agreement within the literature around how best to assess the quality and robustness of qualitative research (Hannes, 2011) and whether it even should be done in the first place (Loh, 2013). As explained by Elliott, Fisher and Rennie (1999) having quality criteria is somewhat at odds to the ethos of qualitative research. Regardless, there is a general consensus amongst qualitative researchers that considerations for assessing and ensuring quality within qualitative research are required.

Guidelines for assessing research quality typically consist of checklists of criteria or procedures upon which the research can be implemented or assessed (e.g. Dixon-Woods, Shaw, Agarwal & Smith, 2004; Elliot, Fisher & Rennie, 1999; Yardley, 2000). One evident flaw in the development of generic qualitative appraisal tools, however, is that there is an implicit tendency to treat qualitative research as a unified field (Dixon-Woods et al, 2004). With vast diversity within qualitative research at levels of data collection, methodology and underlying epistemological position it is clear that a 'one-model fits all' approach is not sufficient.

Specific attempts have been made to provide guidance on quality appraisal for thematic analysis (Braun & Clarke, 2006; Fereday & Muir-Cochrane, 2006). Whilst these guidelines ensure appraisal occurs at each point within the thematic analysis process, qualitative data is mostly still dependent on researcher interpretations of the data. The interpretive process integral to qualitative research has been a longstanding critique (Denzil, 2009) that has instigated researchers to question the worth and usability of qualitative research methods. Establishing 'trustworthiness' is one way in which researchers can demonstrate that their research is worthy (Lincoln & Guba, 1985). Lincoln and Guba (1985) define trustworthiness using four criteria namely credibility, transferability, dependability and confirmability. These criteria have been outlined as conducive for conducting rigorous thematic analysis (Nowell, Norris, White & Moules, 2017) and so were used to guide the current research process. Table 7 reports techniques used within the research to ensure trustworthiness.

Table 7

Means of establishing trustworthiness; criteria and techniques employed within this research

Criteria	**Techniques**
Credibility	Prolonged engagement with the data Peer debriefing Inclusion of both confirmatory and refutational approaches to analysis Verbatim quotations from the raw data used throughout analysis
Transferability	Thick description of methodology and procedures Purposeful sampling of participants with pre-determined inclusion and exclusion criteria Description of the context of recruitment and sample characteristics Sample taken from clinical population and NHS services
Dependability	Audit trail of analysis Notes, reflective diary and supervision records Discussions with doctoral colleagues- peer debriefing Inconsistency checks
Confirmability	Theoretical, methodological and analytic rationales provided
All of the Above	Reflective diary

2.7.1 Credibility. Credibility is concerned with whether participant experiences fit with the researcher's representations (Lincoln & Guba, 1989). Several recommended techniques were used to ensure the credibility of the research findings. Firstly, the researcher facilitated prolonged engagement with the participants' experiences by conducting, then transcribing the research interviews. This provided additional opportunities to engage with participant experiences and create a truer understanding around what the data represented. Secondly, research ideas, processes and reports were frequently discussed or reviewed by doctoral colleagues. This external review process

assisted the researcher in decision-making and enabled the inferences and conclusions drawn within the study were ratified and peer-reviewed. Notably the process of review facilitated the researcher in "*testing their growing insights*". (Gubi, 1985) (p. 85). Furthermore, the inclusion of the refutational stage of analysis ensured that contradictions within the data set were acknowledged and represented. This analysis of 'negative cases' (Lincoln & Guba, 1989) further enhanced the credibility of the analysis process and research findings.

2.7.2 Transferability. Transferability is considered the degree to which the research findings can be applied to alternative contexts (Bitsch, 2005). In order to facilitate transferability, the researcher ensured a 'thick description' (Li, 2004) was provided around the methodology employed. In particular the context and procedures for data collection were made explicit (see section 2.3). Likewise, the rationale and steps for analysis were detailed (see section 2.2.5 and 2.5) and made clear to enable others to replicate the study and make adequate comparisons to other contexts. Transferability was also facilitated through the purposeful sampling of individuals who had received support from tier three NHS community PD services. Although it is acknowledged that variations within services are expected, the specific selection of recruitment sites facilitated a contextual understanding of the individuals who took part.

2.7.3 Dependability. Dependability is concerned with whether the findings, interpretations and conclusions drawn can be related back to the original data set. Several methods were used to ensure dependability. Firstly, during the analysis an excel document was created to keep a record and form an audit trail of each step taken during the analysis process. Researcher notes, a reflective diary and supervision records were also kept as a record of each decision made throughout the research process. During the development of the deductive coding framework and throughout the analysis, the research supervisors repeated sections of the coding. Comparisons were made during supervision and inconsistencies were discussed; this process enable initial coding to be representative of the original data. Whilst designing the research, the researcher also met with an independent research academic to discuss the method of analysis and the ideas they had around including the additional refutational stage of analysis (see section

2.2.7). The discussion facilitated critical reflections around the existing procedures for thematic analysis and enabled the researcher to reflect on their decisions and rationale for inclusion of the refutational stage.

2.7.4 Confirmability. Confirmability considers whether or not research findings could be confirmed or supported by other researchers if the study was replicated. Confirmability measures seek to ensure the researcher's findings are not imagined and are in fact derived from the research data. According to Lincoln and Guba (1985) when all other criteria are met confirmability is achieved.

2.7.5 Reflexivity. A reflective diary was utilised throughout the research process to reflect on theoretical, methodological and analytical decisions. Planned and spontaneous reflections were also used to review processes (e.g. interviewing technique) and capture interesting or ambiguous observations (e.g. participant responses) (See extended paper section 5). Reflective practice is further method for establishing confirmability (Koch, 2006).

3. Extended Results

Within this extended results section additional recruitment data are provided detailing the response and completion rates obtained within the research. Additional themes from the data analysis have already been reported and discussed within Paper 2.

3.1 Recruitment Data

During the development of this research, it was difficult to estimate the required number of participants needed in order to meet the sample size for the project. Previous qualitative studies recruiting individuals discharged from community PD services did not exist. Estimates were instead calculated using data from an annual review from one of the recruitment sites and through discussions with clinical psychologists within the field. Reporting recruitment data below may provide a helpful point of reference for future studies attempting to recruit from a similar service or population.

A total of 106 participants were discharged from four different NHS tier three community PD services within a three-month period. Of those discharged, three individuals were assessed and determined ineligible by a professional within the service. Two individuals were excluded due to risk concerns and one person was unable to provide informed consent. Seventy-six (74%) individuals experienced a planned ending and twenty-seven (24%) experienced an unplanned ending. Thirteen individuals, all of whom experienced a planned ending, responded to the invite resulting in an average response rate of 12.6%. The response rate found within the study equates to a 1:8 ratio, which matches the proposed estimate indicated by clinicians in the field. Overall, eight of the individuals who responded, consented to take part in the study, resulting in an average completion rate of 7.8% or 1:13. The remaining five individuals who responded but did not participate were uncontactable.

4. Extended Discussion

Additional themes and key points have been discussed in paper two. Within this section two further points of discussion will be considered; staff ambivalence from an attachment perspective and a model for understanding boundaries in clinical practice. These additional points relate to the research findings but were not deemed necessary for inclusion in the journal papers. Additional strengths, limitations and methodological considerations will also be discussed. Further recommendations conclude this section.

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4.1 Understanding Staff Ambivalence from an Attachment Perspective

The findings of paper two indicate that health professionals may also experience emotional difficulties when ending therapeutic relationships. From an attachment perspective (Bowlby, 1980), the ending of therapeutic relationships will also activate the therapist's attachment systems and provoke an appropriate attachment response. In contrast to the literature on therapist attachment styles (Bucci, Seymour-Hyde, Harris & Berry, 2016), the findings suggest that some therapists responded in ways that are more indicative of an insecure-ambivalent attachment style. Therapist's affective responses may be understood as a reaction to working with individuals with a PD diagnosis, who characteristically struggle with the fear of abandonment and loss. Supporting research

by Boyer and Hoffman (1993), reports that therapists reactions to endings were predicted by their perceptions of the service users' sensitivity to ending. Further research exploration into therapists attachment behaviours, however, in the interim it may helpful if health professionals are provided opportunities to reflect upon their attachment styles relative to their experiences of ending therapy.

4.2 A Model for Understanding Boundaries in Clinical Practice

The findings from paper two suggest that 'boundaries' play an important role in determining how service users experience endings from NHS community PD services. The researchers provide a model and supportive narrative for understanding the different boundaries of therapy and how violations impact how the loss of therapy is experienced and responded too. Within the literature there is only one other known model for understanding boundaries; the 'Boundary See-Saw Model' (Hamilton, 2010).

The boundary see-saw model was developed upon the principles of Cognitive Analytic Therapy [CAT] (Ryle & Kerr, 2002) to provide an understanding of the different boundary roles taken by health professionals when interacting with service users in therapy. The model outlines three distinct roles; the 'security guard' and the 'super-carer' at oppositional ends of the see-saw and the 'negotiator' in the idealised middle ground. These reciprocal roles and the visual see-saw analogy can be used to reflect upon therapist-service user reciprocal roles and determine whether boundaries are effectively managed in practice. Having models to refer to within supervision or where appropriate during therapy, may highlight salient issues and guide therapists to modify how they maintain boundaries within the therapeutic relationship and towards the ending of therapy.

4.3 Additional Strengths

4.2.1 Novel contribution.

This research provides a novel contribution to the existing literature by offering a qualitative account of service users' subjective experiences of endings. The findings across the two papers adds to our existing understanding of the topic and offers new

insights into both future research developments and in how endings research may inform clinical practice.

4.3.2 Recruitment strategy.

One additional strength of this research is that recruitment was not limited to one lone service: instead participants were recruited from across four different sites and four different NHS trusts. Through this recruitment strategy, the researchers were able to obtain the required sample size. Participant experiences were also reflective of a range of service and therapeutic models, length of treatment and modes of therapy (1-1 and group). Given that themes were identified across the range of participant experiences, this would indicate that findings are not specific to contextual factors and may be considered a representation of ending experiences more generally in PD community services.

4.3.3 Methodological advances.

The researchers included an additional 'refutation stage' of analysis as a measure for minimising researcher bias and was incorporated into the existing thematic steps of Braun and Clarke's framework (2006). The adapted process of analysis was thoroughly considered relative to the limitations of TA and explicitly acknowledges the process of identifying data (codes, themes) that refutes initially developed themes. On this basis the research has offered an additional step for conducting TA that may benefit future researchers using a TA methodology. The additional 'refutational' stage would need to be empirically tested and compared side by side with Braun and Clarke's (2006) original six-steps.

4.3.4 Clinical relevance.

Another strength of the research is that the findings have been extrapolated into clinical practice recommendations and therefore provide an additional source of evidence-based guidance for health professionals seeking advice on how to manage endings. Research activities aim to inform clinical practice in this way, however, the available evidence is often not representative of observed change in clinical practice (Kitson, 2008). Transforming the findings of the study into recommendations that can

be applied in clinical practice is therefore considered to be an important dissemination task (Curtis, Fry, Shaban & Considine, 2017).

Another strength of the research is that it encourages a critical discussion around how endings are experienced and managed within clinical practice. Akin to the theme 'endings held in mind' within paper one, talking about endings in a research capacity may provide a level of exposure for staff that then prepares them for future endings.

4.4 Additional Limitations

Identifying, discussing and reflecting on the limitations of the research is important, as it enables the reader to understand the research findings in context and ascribe some level of credibility to the conclusions drawn.

4.4.1 Sample representation.

One key limitation of this research is that the findings only represent the views of individuals who experienced a planned ending. As indicated in the literature, individuals who choose to leave therapy early (an unplanned ending), do so for a variety of reasons (Bonsmann & Gubi, 2017). Similarly, how they therefore experience the ending of therapy may be entirely different to those who engaged with a planned ending process. Obtaining the qualitative experiences of individuals who have had an unplanned ending would add to the current findings and provide a broader understanding of service users' experiences of endings. Furthermore, understanding the experiences of those who have 'dropped out' of therapy may indicate how services can better engage individuals in therapy and therefore improve therapy retention rates. Despite inclusion within the current study, those who had an unplanned ending chose not to engage with the research. Indeed, psychotherapy research is yet to capture the qualitative experiences of individuals who experience an unplanned ending from therapy. This highlights a related limitation that the research design did not lend itself well to the recruitment of those who experienced an unplanned ending.

One suggestion for future research would be to introduce the study to all potential participants at the start or during therapy. Råbu and Haavind (2018) adopted a

similar recruitment method, by asking therapists to provide each service user entering therapy an information letter from the researcher; however, they too failed to recruit individuals who experienced an unplanned ending. Research attempting to recruit this elusive group of service users directly through a service has been a challenge both in the current research and in other recent studies. An alternative would be to recruit participants using methods that that do not involve a service (e.g. social media); however, this may bring about new challenges around ensuring the sample is representative.

4.4.2 Sample variation.

Participants were exclusively recruited from NHS tier three community PD services that provided specialist support to individuals whose needs cannot be met by a traditionally CMHT. The aim was that recruiting from one type of service would provide some consistency across recruitment sites. However, the four sites each offered different models of service delivery. Consequently, the experiences of participants who engaged with the study related to both individual and group therapies delivered from a range of psychological perspectives. The variations in the service and therapy that participants received may be considered a limitation of the study as the diversity of the sample means inferences cannot be drawn about ending experiences from specific therapy modalities or approaches. Although this was not the aim of the current study, further research may wish to explore endings more specifically in either group or individual therapy. Given the different theoretical conceptualisations of endings, there may also be value in researching service users experiences of endings from particular therapeutic approaches (e.g. CBT).

4.4.3 Quality appraisal checks.

Braun and Clarke (2013) recommend that good research practice would involve having a second researcher code the data. Although both deductive and inductive codes were checked at numerous different points by the two research supervisors neither were completed entirely as a parallel process. Alternative means of assuring quality were conducted and are evidenced (see section 2.7).

4.4.4 An alternative methodology.

Unintentionally, within journal paper two a model is proposed to understand the role of boundaries in service users experiences of endings. One consideration therefore may be that a grounded theory approach to data coding and analysis may have been more appropriate. A grounded theory approach would have involved systematically coding and analysing the data to generate a new theory for understanding service users' experiences of endings. However, grounded theory does not fit well with the critical realist epistemological stance of the research. Further explained, grounded theory generates higher-level interpretations (or theories) from within the data set and does not consider theoretical preconceptions or knowledge drawn from other sources (Corbin & Strauss, 2008). In contrast critical realism would encourage engagement with alternative theories in an attempt to better explain that reality. In summary, the inferences and conclusions drawn from a grounded theory approach are entirely inductive and therefore in conflict with the critical realist stance of the research which has included abductive and retroductive inferences (Meyer & Lunnay, 2013).

4.4.5 Recruitment challenges

One of the key difficulties with conducting research on service users' experiences of endings is that the researchers experienced several challenges when attempting to recruit individuals who had already been discharged from their respective service. Due to ethical concerns and issues related to data protection participants had to be identified and contacted by the service; the researcher was therefore reliant on the services involved to initiate recruitment.

Another challenge was that the researchers also struggled to reach their proposed target sample size. Firstly it is worth noting that due to a lack of previous research on the topic it was difficult to estimate the response rates required (see section 2.3.8). There is likely to be a number of reasons why individuals would not want to engage in the study or research generally. However, individuals with a PD diagnosis notably struggle with interpersonal difficulties and abandonment and therefore additional challenges with engagement were anticipated. Ethics were revisited during the study to include a further site to enable the researchers to reach their target sample size.

4.5 Further Research Recommendations

This research contributes to the dearth on literature on service users' subjective experiences of endings and offers new insights into how endings could be better managed in clinical practice. It must be acknowledged that participants were only recruited from one type of service (NHS tier-three community PD services) and therefore the conclusions drawn are only representative of these settings. Further research exploring different types of PD services (e.g. tier 4 inpatient services) or other more generic services (e.g. Community Mental Health Team) would help understand whether or not similar experiences occur. Additional research would provide evidence to support whether the findings are specific to a PD population or whether they are indicative of a more general ending experiences. Evidence from such studies would determine whether generic or specific recommendations are provided to support health professionals with managing ending in therapy.

4.6 Dissemination

The research emphasis was around service users' experiences of endings and so the findings were firstly disseminated at a service user involvement event that focussed on transitions (2018)[34]. The researcher also aims to submit the two papers for publications and given the relevance of the research to clinical practice, efforts will be made to inform NICE of the research findings.

[34] Transitions- Service User Involvement Event, 13th November 2018, Carriageworks Theatre, Millenium Square, Leeds.

5. Critical Reflections

Reflective practice is considered an essential skill amongst Clinical Psychologists (British Psychological Society (BPS), 2008) that facilitates greater self-awareness, promotes clinical competence and enhances critical thinking skills (Cooper & Wieckowski, 2017). Within this section I have therefore chosen to critically reflect on particular experiences that I felt improved my effectiveness as both a researcher and a clinician.

5.1 Observer or Participant

After conducting the first research interview I reflected on how my previous research experiences and perceptions may have influenced my interviewing style and approach.

> "*So, I have just completed my first research interview. I did feel a little nervous, but it went reasonably well especially considering my questionable interviewing technique! Listening back to the recording I can hear how stunted I am in my approach. I often interrupted the flow of the interview by saying 'okay' or 'yes' to the participant's response and I leave several awkward pauses. I didn't follow-up on the implicit unspoken thoughts and feelings of the individual's experiences, nor did I seek to clarify what they were saying. Yet, ordinarily in clinical practice I would paraphrase, reframe or summarise what the individual was saying to seek clarify or further understanding, but here, I guess I felt I had to be an observer not a participant in the discussion. Luckily for me the participant was forgiving and often ignored my interruptions, thankfully! So, thinking about why I felt I had to be an 'observer'. During the interview I did notice, an almost pull to remain objective, like I didn't want to put words into participant's mouth, I wanted their true experiences untainted by my own pre-conceived ideas and understanding. I guess this stems from my acknowledgment throughout the research process that I do have previous experiences and knowledge of conducting research in this area. So, from this I do have some ideas of what to expect from participant experiences. I guess I was worried about unintentionally finding what I perhaps expected to find. Yet rather than acknowledge and accepting this, as the research methodology does,*

in practice I've instead clearly attempted to bracket it off and remain neutral in my interviewing style which inevitably has resulted in me being rather distant from the research interview and participant. If I had put on my 'clinical hat' explored, expressed and sought clarity, it is likely that I would have gained a more thorough and deeper understanding of the participants experiences of endings. Thinking about the clinical interviews I have conducted in practice, if I had been so detached from the interviewing experience as I was within this first research interview I would have soon become stuck. A big part of therapy is about building that alliance, reflecting, showing an understanding, re-framing things so the service-user gets that you get them. In research, the objective is the same, you want to understand, so the approach surely should be no different. Upon reflection I think it was naive of me to think (although not consciously) that it was necessary for me to remain neutral as an objective researcher. When you put on your 'research hat' you don't just stop being a clinician. You take with you your skills, experiences and knowledge with you. I have another interview booked in soon, so I am going to relax my approach, drop the guard and remember to use my clinical interviewing skills. My hope is that this will improve the quality of the interview."

Following my second research interview I further reflected on my revised interviewing technique,

"*This was definitely a much better interview. It flowed and felt more like a conversation between the two of us. I think paraphrasing and reflecting within the interview helped to improve my understanding of the individual's experiences and in return I think the participant felt understood. Throughout this interview I noticed how I would often ask the participant how certain experiences made them feel. Yes, I would typically do this in clinical interviews, however I think my previous knowledge around the emotional impact of ending therapy made me even more inclined to ask and explore the participant's emotional responses. By doing so, seemed to encourage the participant to provide a rationale and further discuss what it was about their experiences that*

made them feel sad, angry, etc. In fact, through little prompting the participant provided some really insightful experiences. It's made me think back to specific points in the first interview and wonder whether if had I been more exploratory if I would have gained a better understanding of some of the experiences they talked about."

5.2 The Impact of the Research on Clinical Practice

Similar to how my prior views and experiences influenced different aspects of the research, my acquired knowledge has in turn influenced how I manage endings in clinical practice.

During my final week on placement I reflected,

"*So it's nearly the end of my final week on placement and this week I ended therapy with the remaining individuals on my caseload. The recommendations I summarised from the research findings were used as a clinical guide to support the ending process in parallel to the NICE recommendations. Service users seemed receptive to the way I managed their endings, one even commented in their final session that they felt 'empowered' to move on. However, this comment made me think about some of the other endings I've managed with service users this week. In particular, the challenges you face as a clinician when managing an ending where the individual doesn't really have anything to move onto. When developing the recommendation around empowering the ending, I drew upon the post-traumatic growth literature to suggest that ending should be viewed as pivotal point, the start of a new chapter, a motivating positive re-frame for those who are struggling to come to terms with ending therapy. However, in reality empowering the ending was harder than expected particularly when, due to recent cuts to services (both NHS and local community services) I was discharging individuals in the community with no support other than a GP. It felt harsh. Empowerment in this context became more about empowering an individual to consider the benefits of moving on from therapy (being independent) rather than moving onto a new chapter. These*

reflections further highlight to me an important point around the interpretation and use of clinical guidelines, in that recommendations should always be implemented flexibly in a person-centred manner that considers the wider social and contextual factors."

I then go on to reflect on how implementing the research recommendations has enhanced my experiences of managing endings in practice.

"Ending processes seem integrated into my skill set now which has definitely made things easier when comparing these endings with previous therapy endings. Thinking about the utility of the recommendations, they definitely take away some of the thinking that you do around planning the ending, the process does become less ambiguous for both you and the service user. What is this about though, I guess on one level it makes you feel supported, offers some kind if containment. But its more, I, it takes the responsibility away, yes, endings become less ambiguous because in part the responsibility is removed."

5.3 Openness of Participants

In addition to keeping a written diary with planned reflections, I also kept spontaneous audio recordings to capture my immediate thoughts, feelings and reactions at different points within the process (e.g. following recruitment site visits, after each research interviews or supervision). My reflections are illustrated below with extracts from audio recordings and supervision reflections.

After conducting my first couple of interviews I recall feeling initially surprised by the openness of participants to discuss their experiences with such detail and emotional articulation.

"Second research interview just completed with a young female. It seemed to go really well yes, she was really forthcoming with information and I didn't feel like I had to press or prompt much, yes, actually, yes she made it

quite easy for me. She spoke about her experiences with real detail, like she knew how she felt" (Participant 2)

"So, I've just completed my third interview with a young female. First thoughts- I'm again surprised really at how expressive she was, like she talked about her thoughts, fears, emotions and was really reflective about her experiences." (Participant 3)

Having discussed my initial responses within supervision I then reflected,

"*Thinking about it I really shouldn't be that surprised that participants were so open to discussing their experiences. I remember when I worked as an assistant psychologist within a community PD service, I co-facilitated a DBT group that supported individuals with a diagnosis of BPD. Service users were mostly really open and reflective about their experiences and how the content of the sessions related to them, which generated some really good discussions. Similar to how I feel about the current research interviews, I always ended the sessions feeling like 'wow that went well'. There were however a few occasions when it almost felt like an individual over-indulged information about their personal experiences, almost being too open with the information they shared. Reflecting, the openness of participants to share information both in therapy and research is unlikely to be a coincidence. From my knowledge of PD and the challenges an individual with the diagnosis may encounter, I understand that underlying attachment difficulties may prompt an individual to behave in a way that seemingly prevents imagined or actual abandonment. Using this understanding it may be that 'opening up' is a learnt behaviour that functions to connect the individual with others in an attempt to quickly form relationships and establish a perceived sense of security; albeit temporary.*

Aside from this, and separate from any associations with a PD diagnosis, participants who took part in the research had just received some form of psychological therapy. Therefore, it is likely that participants would be familiar with discussing their thoughts and feelings and also reflecting on their experiences- its common practice in most therapies. At the point of interviewing, participants may be used to opening up and would likely already have a

repetoire of emotive language they can readily draw upon to describe their ending experiences."

5.4 A Story to Tell

Following the last research interview, I reflected upon who opted into the project and the function of their involvement.

"*The willingness of participants to give up information about their experiences led me to think about the participants as a whole who opted into the project. What I observed throughout most of the interviews was that it felt like participants had a story to tell. Endings didn't just happen they were experienced. Participants told me all about their personal difficulties, relationships in and outside of therapy, and their absolved access to services-all in relation to their ending experiences. Metaphorically speaking, when you tell a story you generally want someone to listen- perhaps a function of the research interview is that it gave participants an opportunity to be heard. This perhaps reflects an un-met need, in that services did not provide sufficient opportunity for participants to process the ending of therapy. This was certainly the case for one participant who if I remember correctly described how everyone ran away in their own direction because they were not helped to understand the pain of ending. These reflections highlight a further consideration around whether or not the research interview in itself extended the therapy received. Did the research interview contribute towards the individuals' ending well? It's certainly possible that discussing the ending helped in some way with processing their individual ending experiences. It's ironic really, the research advocates the importance of managing boundaries yet the interview itself may be perceived as breeching the boundaries imposed by time-limited therapy."*

Thinking about the individuals who opted into the project led me to also consider the individuals who did not take part.

"*During the research we were unable to recruit anyone who had experienced an unplanned ending. When I think about the reasons why those individuals who experienced an unplanned ending would not want to participant in the research, I was initially drawn into speculating that the discussion of endings (taking part in this research) was avoided, in a similar vein to how perhaps the ending of therapy was avoided. It is easy to formulate from an attachment perspective why an individual with a PD presentation would avoid an ending. There may be other reasons. Reflecting on the method of recruitment it wasn't exactly welcoming for individuals who had experienced an unplanned ending. Thinking about it, it was unlikely that an individual who chose to end their therapy would then respond to an invite received from the service. Perhaps recruiting through other avenues would have attracted these individuals to discuss their experiences. Other avenues, maybe like local support groups if they exist or social media groups. This certainly highlights a limitation of the research in that the recruitment method inadvertently makes it difficult for those who experienced an unplanned ending to participate."*

5.5. Concluding Reflections

The critical realist epistemological position of this research states that multiple versions of the truth exist that are each determined by individual differences in experiences, perceptions and beliefs. Given this position, as the researcher I inevitably brought my own personal views, and experiences (personal and professional) to each stage of the research process; including how interviews were conducted, interpreted and analysed. The potential implications of my individual bias have been acknowledged and addressed within the research methodology to enhance the scientific quality of the research process. However, as a reflective practitioner my written and audio diary entries have enabled me to review my experiences, refine my research skills and take account of how my own views and experiences influenced the research process. Although attempts were made to minimize the impact of bias, it is acknowledged that the findings of this research are a co-construction of participant experiences, my interpretations and my supervisor's guidance.

5.6 Key Learning Points

- When you put on your ‘research hat’ you don’t just stop being a clinician.
- Embrace the skills, experiences and knowledge and take them with you.
- Acknowledge how your bias, experiences and pre-conceived ideas influence your research decisions or approach.
- Use acquired research knowledge to inform your clinical practice.
- Ensure clinical guidelines are implemented flexibly in a person-centred way that considers any wider social and contextual factors.
- Be critical about why individuals did or did not participate in your research.
- Continue to critically reflect on your research and clinical experiences

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Table of Appendices

Appendix A- Letter to the Service

Dear, ….

I am trainee clinical psychologist currently conducting research as part of a doctorate in clinical psychology at the University of Lincoln. The research has been approved by both Lincolnshire Partnership Foundation Trust NHS R & D (IRAS Number: 217668) and the University of Lincoln's Ethics Committee (Ref: PSY1617140); a letter of access has been obtained enabling me to conduct the research across different trusts (please find attached approval letter).

Individuals who receive support from personality disorder services characteristically struggle with interpersonal relationships and therefore may find the ending from a service a challenging experience. The ending of therapy is considered an important and integral part of the therapeutic process, yet despite an abundance of literature there is limited knowledge around how service users experience the ending from a community personality disorder service.

The final stage of my research aims to answer the following questions:

1. How do individuals experience planned endings within community PD services?

2. How to individuals experience unplanned endings within community PD services?

In order to answer the research question I aim to conduct interviews with approximately 6-12 service users who have recently been discharged from the service to explore their individual experiences of endings. Individuals who have opted to leave the service prior to the planned end date may offer a different perspective on how endings are experiences and may contribute an alternative view on how endings should be managed. Therefore, in addition I aim to interview 4-8 individuals who left the service before the ending and therefore may offer an alternative experience.

I therefore write to you to invite the service to facilitate the recruitment of participants to take part in this stage of the research.

I have provided some additional information below to outline the exact details of what this would involve for the service. The research is designed to cause minimal disturbances to routine practice and therefore I will be happy to attend the service to will reduce staff involvement.

I would be happy to discuss the research further on the telephone, my number is: **07914679396**

What will involve it for the service?

An initial telephone call will be arranged at your convenience to discuss the research and answer any questions you may have.

If you agree to act as a recruitment service a discussion with a contact person within the service would follow to identify any service users who have been discharged within the last 3 months. If the service believes that involvement in the research would pose a risk to an individual then we ask that these individuals are not included in the recruitment

phase. Pre-prepared research information packs, (including participant information sheet, response form and consent form; see attached) will be available to send to potential participants from the service. I will attend the service to minimise any disturbances to normal working practice. To ensure the research is inclusive participants will be offered the option to complete either a telephone or face to face interview. If a face to face interview is chosen then interviews will need to be conducted on a trust site. In this instance we request that a room is made available for the researcher to conduct the interview; this will be arranged with the service at a time that will cause minimal disruption.

What will it involve for service users?

Service users who respond to the invitation will be contacted and given the opportunity to discuss their involvement and ask any questions before completing a consent form.
Interviews: During an initial telephone discussion, service users will be given the opportunity to ask questions about their involvement and the terms of confidentiality will be explained. A telephone interview or face to face interview will be arranged at a convenient time with consenting participants. The interview will follow an interview schedule however the interview will primarily be led by the participants. Participants will be offered a break mid-way through the interview and at the end will have the opportunity to reflect on the experience of being interviewed.

What if an individual becomes distressed during the interview?

All participants will be reminded at the recruitment stage and at the beginning of the interview that sometimes interview discussions can evoke strong emotion. If they feel that participation would be too distressing then they are advised to either not take part, withdraw or take a break at any point during the discussion. It is not anticipated that there will be any risks or detrimental effects of taking part, however if the discussions are becoming too heated or the interview is having a negative impact on the participant then the topic will be changed or the interview will be stopped all together. I have previous experience in facilitating discussion around the topic of endings within community personality disorder services and therefore I will draw on previous skills in managing the discussions.

How will participant interviews be analysed?

All interviews will be recorded using a trust approved Dictaphone. Recordings will be transcribed and any identifiable information will be removed to protect individual anonymity. Interviews will be analysed using thematic analysis (Braun & Clarke, 2006) which looks to create themes from the data collected.

How will participant information be stored?

All participants will be assigned a participant number at the transcription stage. Data will be stored on a password protected computer file accessible to the research team only. Consent forms and response forms will be stored separately in a locked filing cabinet at the University of Lincoln and will later be moved into the University archive service upon

project closure. In accordance with University storage policy all paper-based and electronic data related to the project will be stored for seven years.

What will happen to the findings of the research?

It is intended that the research findings will be published in a relevant peer-reviewed journal and submitted for presentation at the British and Irish Group for the Study of Personality Disorder (BIGSPD). The service will also receive a summary of findings.

Who is the research sponsor?

The research is sponsored by the University of Lincoln.

Who has approved the research?

The study has been reviewed and given favourable opinion by the University of Lincoln Ethics Committee and NHS R & D.

Researcher Contact Details:

Tel: 07914679396
Kimberley Webb-Trainee Clinical Psychologist
School of Psychology, College of Social Sciences, First Floor, Sarah Swift Building, University of Lincoln, Brayford Pool, Lincoln, LN6 7TS

Appendix B- Interview Schedule

Project: How are Planned and Unplanned Endings Experienced in NHS Community Personality Disorder Services?

Checklist: Introduction, confidentiality and consent, explain interview process, audio recording, any questions.

The following questions offer only a guide for the interview. The questions will not be following strictly and additionally questions or prompts may be asked to support the more in-depth description of participant experiences.

Q: Firstly, please could you tell me about the support you received from the service?

Who did you see? How long? What support?

Q: What were your experiences of ending support from the service?

-Planned or unplanned? (reasons for ending)

-Thoughts and emotions around the time of discharge

- How did you feel leading up to the ending from the service?

Q: Was there anything in particular that made the ending difficult? Was there anything that made the ending easier?

-What was it about that experience that made it difficult/ easier?

-How did it make it easier/ difficult?

-Why was this important?

Q: How was the ending prepared for?

-When was the ending first discussed within the service? Was it helpful? Was it expected?

-How did the service prepare for the ending?

-How did you prepare for the ending?

-How involved were you in the process?

-What other support did you receive?

Q: How should endings be managed within the service?

- What could be done differently? What would you not change?
- How would this impact on an individual?
- Why would it be important?

Appendix C-Letter to the Participant

Dear,

You are invited to take part in an interview which looks to explore your experiences of ending the support you received at Leeds PDMCN service. The interview can be conducted either face to face or over the telephone depending on what you prefer.
Before you decide whether you want to take part, please read through the enclosed leaflet carefully. It is important that you understand why this project is taking place and what it may involve for you. Feel free to discuss this project with family, friends, your GP or anyone else you feel you would like to share it with. If you wish to discuss the project with the research team please contact Kimberley Webb on: **xxxxxx**

Many Thanks

Kimberley Webb- Trainee Clinical Psychologist
University of Lincoln
Department of Clinical Psychology
Sarah Swift Building
University of Lincoln
Brayford Pool
Lincoln
LN6 7TS
01522 886029

Appendix D- Participant Information Sheet

You are invited to take part in an interview which aims to explore your experiences of ending the support you received at Leeds PDMCN service.

Before you decide whether you want to take part, please read through this sheet carefully. It is important for you to understand why this project is taking place and what it may involve for you. Feel free to discuss this project with family, friends, your GP or anyone else you feel you would like to share it with. If you wish to discuss the project, please contact Kimberley Webb on: **xxxxxxxx**

Title of Project: How are planned and unplanned endings experienced by service users in community personality disorder services?

Why are we doing this research?

There is currently little research on how service users' experience an ending or discharge from a service. We understand that individuals may leave the service when support ends, or others may make a decision to leave the service early. We are interested in both experiences. Currently, the research on individuals who leave a service early is very limited therefore by obtaining service users' experiences will hopefully provide us with a unique perspective on the ending experience.

What we know so far is that 'endings' are important, but little is known about how they are experienced by service users or how they can be better managed. Understanding your experiences will provide evidence to support more effective services in the future.

Why have I been invited?

You have been invited to take part because you were identified as someone who has recently left the service. You may or may not have a diagnosis of personality disorder; this does not matter as the project is interested in anyone who has received support from the service.

What will I be asked to do?

You will be asked to take part in a telephone or face to face interview at a time that is best suited for you.

How long will the interview last?

We estimate that the interview will last between 30-60mins. However we are interested in your experiences, so the interview length will be guided by how much you wish to say. The interview will be recorded using an approved recording device; this will enable us to keep an accurate record of the interview content.

If you choose to take part in a telephone interview this will be arranged at a time convenient with yourself. If you chose to take part in a face to face interview this will

take place on an NHS site, possibly the service you attended. Arrangements will be made to ensure this is at a time convenient for yourself.

Do I have to take part?

It is entirely up to you whether you choose to take part or not. If you choose to take part, you will be given plenty of opportunities to discuss the project further before being asked to sign a consent form. If you do take part, you can withdraw at any time up to the point of analysis. If you choose to withdraw you would just need to ring or contact the research team and they would remove and destroy all your data from the project. Withdrawal will not affect any of the care you receive.

What will happen if I decide to take part?

Please either contact the research team on: **xxxxxxx** or complete the response form and send it back to us in the stamped addressed envelope. You will then be contacted to discuss the project and to arrange a suitable time to conduct the interview.

What happens after I have taken part?

Once the interview is complete, you will be given the opportunity to discuss the process of being involved in the interview. You will be reminded of what happens next with the data and we will offer contact details of services, should you feel you need further emotional support.

I'm interested… how do I take part or find out more information?

If you are interested in taking part or would like further information, please complete the enclosed response form or contact the research team on **Tel: xxxxxx.** By completing and returning the response form you are under no commitment to take part in the project. Once received, you will be contacted to have an informal chat about the project and give you the opportunity to ask questions before you decide whether you wish to take part.

If you decide to take part, you will be sent further information about the project, and we will ask you to sign a consent form. At this point, arrangements can be made to conduct the interview at a time convenient for yourself.

Researcher Contact Details

Kimberley Webb- Trainee Clinical Psychologist
School of Psychology, College of Social Sciences, First Floor, Sarah Swift Building, University of Lincoln, Brayford Pool, Lincoln, LN6 7TS

What else do I need to know if I decide to take part?

Any information that you provide as part of the research will be kept both confidential and anonymous. We will give all your research data a code so that you cannot be identified. We do not anticipate any immediate risks involved in taking part in the study however the interview topic may or may not evoke some emotional feelings for you. If

you become distressed at all during the interview, please inform me and the interview can either break or stop. Likewise, if I feel that the interview is causing you too much distress, then I will discuss thi with you before ending the interview. Information on local support services will be provided.

What are the possible benefits of taking part?

By taking part in this research, you will be contributing towards the limited evidence base on how endings are experienced by service-users. The hope is that this research will inform current clinical guidelines and help provide a better service for individuals who receive support from a community personality disorder service.

What will happen with my interview data?

Following the interview, the audio recording will be transferred onto a password protected storage device. The audio recording will be transcribed (typed out), and any identifiable information will be removed or edited to protect your identity. It may be that a professional transcription service is used, if this is the case, they will sign a confidentiality agreement beforehand.

The data will be analysed alongside other transcripts however we may also use direct quotes from your interview within the write-up. The aim is that the research will be published in a journal, presented back locally to personality disorder services and also at a national personality disorder conference. A summary of the findings will also be sent to you if you request one on the consent form. Please note that the research team do not have access to your medical records and therefore if you were to change your address we ask that you update the research team.

All your interview data will be kept anonymous and will only be accessible to the immediate research team. On rare occasions, the regulation authorities (NHS Research and Development Department) that ensure we are conducting research correctly may ask to check we are following the right procedures. On such occasions, we will ensure that your data is only accessed for monitoring purposes.

What if there is an issue or something goes wrong?

We do not anticipate that anything will go wrong. However, if you do have any concerns about any aspect of this project then do not hesitate to contact the research team, who will aim to help you or answer any questions. If you remain unhappy and feel you would like to make a formal complaint then you can contact:

School of Psychology Research Ethics Committee (SOPREC), College of Social Science, University of Lincoln, Lincolnshire, LN67TS. Email: soprec@lincoln.ac.uk

Who will know that I have taken part in the study?

Although the community PD service has helped identify and contact individuals who may be suitable for this project, the service will not be told if you do decide to take part. Your participation in the project will remain confidential, as will anything you say within the

interview. The only time we would need to break confidentiality is if you tell us anything that leads us to believe either yourself or others are at immediate risk of harm, this will be done to help keep you safe.

Who has approved this study to go ahead?

Before any research goes ahead, permission needs to be sought to ensure that it is safe, ethical and reasonable to do. This project has been checked and approved by the NHS Research Ethics Committee (REF: 217668), the local NHS trust Research and Development department and the University of Lincoln ethics committee (REF:PSY1617140). The University of Lincoln also acts as the sponsor for the project.

Appendix E- Participant Response Form

Project: How are planned and unplanned endings experienced in NHS community personality disorder services?

Name of Researcher: Miss Kimberley Webb

If you are happy to be contacted regarding your interest in taking part in this project please complete the following response form and then return it in the post using the stamped addressed envelope provided. I will aim to contact you within two weeks to provide you with more information or answer any questions you may have. However, in the meantime if you would like to chat about the project please call: **07914679396**
By filling in this response form you are agreeing to be contacted to discuss the research further and to have your questions answered. If you decided after talking that this project is not for you, then we will destroy your contact details.
Thank-you, we hope to speak to you soon!

Name:

Telephone Number:

Preferred time to call me: (please circle) morning afternoon evening

If you have any requirements or further information you wish to provide please let us know in the space below:

Please return this form using the stamped addressed envelope provided to: FREEPOST, Judith Tompkins School of Psychology, College of Social Sciences, First Floor, Sarah Swift Building, University of Lincoln, Brayford Pool, Lincoln, LN6 7TS

Appendix F- Participant Consent Form

Project: How are Planned and Unplanned Endings Experienced in NHS Community Personality Disorder Services?

If you are happy to participate in the project outlined (IRAS No: 217668) in the participant information sheet, please read each point outlined below carefully and initial the box at the end of each statement. Please could you then print, sign and date at the bottom of the page. If you have any questions regarding the content of this form please do not hesitate to contact me on Tel: XXXXX XXXXXX

Please initial box

1. I confirm that I have read and understood the participant information sheet and had the opportunity to discuss the project, ask questions and feel satisfied with the responses given by the researcher. ☐

2. I understand that my participation is voluntary and that I have the right to withdraw up until the point of analysis (minimum two weeks) without reason. ☐

3. I understand that all data I provide as part of the research will be treated as confidential and that any identifiable information will be anonymized. ☐

4. I give permission for the interview to be audio recorded and agree that any anonymous quotes may be used in the write-up of the research. ☐

5. I agree for my interview to be transcribed by a professional transcription service providing they sign a confidentiality agreement beforehand. ☐

6. I understand that when the project ends, all data will be stored securely in accordance with storage policy in University of Lincoln archive for seven years before being destroyed. ☐

7. I agree to take part in the above study. ☐

_____	_____	_____
Name of Participant (please print)	**Date**	**Signature**

I would like to receive a summary of the research findings and therefore agree for the researcher to keep my contact details in order to send a summary upon completion. All contact details will be erased after this point. ☐

Please provide your email address or postal address below if you wish to receive a summary

Appendix G- Demographic Information Sheet

In order for us to describe the individuals who take part in this research, I would like to ask you a few basic questions about yourself. If there are questions you do not wish to answer then please feel free to leave them blank. If you have any questions please ask me.

Q1. Would you consider yourself as: Male Female Transgender Prefer Not to Say

Q2. What is your date of birth or age?

Q3. How would you describe your ethnicity?

Q4. Have you ever been told that you have any mental health diagnoses? If so, please could you provide details in the box below:

Q5: What support did you receive from the community PD service?

Q6. When were you discharged from the community PD service?

Appendix H- Deductive Coding

Code	Deductive Codes from NICE guidelines BPD
D1	Endings evoke strong reactions in service users
D2a	Endings evoke strong negative emotions for service users
D2b	Endings evoke strong positive emotions for service users
D3	Ending are discussed and planned with the service user
D 4	Endings are structured and phased
D5	In collaboration with other care providers
D6	Support provided during transition period
D7	Completed in collaboration with service user
D8	Contingency plans are communicated clearly
D9	Support options post-discharge are communicated
D10	Plans for ending discussed with family/ carers
D11	Information provided about PALS
D12	Information provided about service user involvement opportunities

Code	Deductive Codes from the literature
D13	Service users anticipate the ending therapy
D14	Ending of therapy evokes powerful emotions e.g. anxiety, fear, frustration.
D15	Anticipated loss of therapy provokes negative emotions in service users
D16	Negative reactions attributed to dissatisfaction of process
D17	Negative reactions attributed to incomplete therapy
D18	Anxieties related to future beyond therapy
D19	Negative emotional reactions to loss of positive therapeutic relationship
D20	Therapeutic relationship important to ending process
D21	Therapist invites contact beyond therapy 'leaving the door open'
D22	Service user requests contact beyond therapy
D23	Service user observed therapist anxiety towards ending
D24	SU views ending as experience of independence and growth
D25	Goal attainment as reason for ending
D26	Goal attainment attributed to positive ending experience
D27	Service user-initiated ending 'personal responsibility'
D28	Preparing for the ending reduces anxieties
D29	Lack of involvement in ending process evokes negative emotions (distress, disempowerment)
D30	Preparation helps service user feel more in control
D31	SU anxiety about how therapist would respond to ending
D32	SU take caution in approaching discussion around ending
D33	SU seeks out approval of therapist to end
D34	Staff respond to ending provokes negative SU response
D35	Staff response to ending provokes positive SU response
D 36	Collaborative decision to end
D37	SU experienced collaborative approach as empowering

Appendix I-Debrief Sheet

Firstly, thank-you for contributing to the research project. As discussed previously the research will now be written up for publication and submitted for presentation at the British and Irish Group for the Study of Personality Disorder Conference, March 2018. By offering your experiences during the interview you have contributed to the growing literature base on how endings are experienced within community personality disorder services. The hope is that by understanding how endings are experienced by those who experience them, namely service-users, then as clinicians we can re-assess how endings are managed in practice. The current NICE guidelines for managing endings are limited and therefore your contributions may also influence such guidance in the future, on a national level.

If requested, you will be sent a summary of the findings to the address you provided during consent. If this has changed please contact us and we can have this update as it will take some time to complete the analysis and get a summary sent out to you. In the meantime if you have any questions or queries related to the project please contact us using the detail below.

You may withdraw from the project without giving reason anytime up until the point of analysis (minimum of two weeks). If you would like to withdraw, please contact the team. All your data will be removed from the project and destroyed, no questions will be asked about reasons for withdrawal.

We understand that, for some, discussing endings can be difficult and may cause some distress during or even after the interview. If you feel you require additional support then please contact your local GP or support services. We have put together a list of local numbers/ services below:

- Samaritans (24 hours): Tel: 116 123 or Email: jo@samaritans.org
- Crisis Team via Single Point of Access (SPA) (24 hours):
- Visit your local A & E department:
- Call **999** should you feel you are in immediate risk

Research Team Contact Details

Kimberley Webb- Trainee Clinical Psychologist Tel: xxxxxxx
School of Psychology, College of Social Sciences, First Floor, Sarah Swift Building, University of Lincoln, Brayford Pool, Lincoln, LN6 7TS
Dr Mark Gresswell- Research Supervisor Tel: 01522 886029
School of Psychology, College of Social Sciences, First Floor, Sarah Swift Building, University of Lincoln, Brayford Pool, Lincoln, LN6 7TS
Dr Thomas Schröder- Research Supervisor Tel: 0115 846 8181
Trent Doctorate in Clinical Psychology, Division of Psychiatry and Applied Psychology, School of Medicine, University of Nottingham, B12 YANG Fujia Building, Jubilee Campus, Wollaton Rd, Nottingham NG8 1BB Tel: 0115 846 8181

Appendix J- Email Confirmation from SOPREC

Email From: SOPREC

Sent: 21st November 2016

Subject: Ethics Application Decision- PSY1617140

Hi,

This is to confirm that your application titled *How are endings experienced by service users in community personality disorder services? Stage 2: How do individuals planned and unplanned endings?* which was submitted for ethical approval, has been Conditionally approved by the School of Psychology Research Ethics Committee.

The following conditions must be met before approval can be granted:

- The participant debrief form seems to be missing (see BB for an example from SOPREC)
- The participant information sheet doesn't seem to include instructions on how participants can withdraw their data. This should be added.
- Withdrawal is stated as 72 hours- change to 2 weeks.

These do not need to come back to the committee. Please make the required changes and notify your dissertation supervisor that they have been made.

Kind regards,
Matt

Appendix K- Correspondence and Confirmation of REC Favourable Opinion

Email From: LEEDSWEST

Sent: 28th July 2017

Subject: 17/YH/0221, IRAS Project ID: 217668 Favourable opinion on further information

Dear Kimberley

Further to your recent application for ethical approval for a new research project, please find attached the letter confirming the Committee's opinion. Please note that hard copies will not be sent unless specifically requested.

Best wishes,
Christie

Christie Ord
REC Manager

Health Research Authority

Room 001| Jarrow Business Centre | Rolling Mill Road, Jarrow | NE32 3DT
T. 0207 104 8086
E. nrescommittee.yorkandhumber-leedswest@nhs.net
W. www.hra.nhs.uk

……..

Yorkshire & The Humber - Leeds West Research Ethics Committee
Jarrow Business Centre
Rolling Mill Road
Jarrow
NE32 3DT
Telephone: 0207 104 8117

28 July 2017

Dear Miss Webb

Study Title: How are Endings Experienced By Service Users in Community Personality Disorder Services?

IRAS project ID:	**217668**
REC reference:	**17/YH/0221**

The Research Ethics Committee reviewed the above application at the meeting held on 14 July 2017. Thank you for attending to discuss the application.

Provisional opinion
The Committee is unable to give an ethical opinion on the basis of the information and documentation received so far. Before confirming its opinion, the Committee requests that you provide the further information set out below.
Authority to consider your response and to confirm the Committee's final opinion has been delegated to a meeting of the Sub-Committee of the REC consisting of the Chair together with Ms Sarah Kirkland.

Further information or clarification required
1. Further consideration of the logistical arrangements for the interview as the Committee strongly indicated that it would not be appropriate to conduct interviews over the phone in this vulnerable population, especially noting the likelihood for distress. Members requested consideration of conducting interviews face to face in a safe, secure and confidential environment where support for the applicant and participant would be readily available.
2. Confirmation that any data on a USB stick would be encrypted and backed up.
3. The Committee recommended that the participant information sheet be proof read to correct minor errors.

The remaining five pages of the letter have been omitted.

……..

Email From: LEEDSWEST

Sent: 31st August 2017

Subject: 17/YH/0221, IRAS Project ID: 217668 Favourable opinion on further information

Dear Kimberley
Further to your recent application please find attached a letter confirming the Committees opinion.
Best wishes
Rheanneon
Rheanneon Fuller
REC Assistant

Health Research Authority

Jarrow HRA Centre | Room 001, Jarrow Business Centre, Rolling Mill Road | Jarrow | NE32 3DT
T. 0207 104 8117
E. nrescommittee.yorkandhumber-leedswest@nhs.net
W. www.hra.nhs.uk

Confirmation Letter Attached to Email

Yorkshire & The Humber - Leeds West Research Ethics Committee
Jarrow Business Centre
Rolling Mill Road
Jarrow
NE32 3DT
Telephone: 0207 104 8117

31 August 2017

Miss Kimberley Webb
College of Social Science
Ground Floor, Bridge House
University of Lincoln
Brayford Pool
Lincoln
LN6 7TS
Dear Miss Webb

Study title: How are Endings Experienced by Service Users in Community Personality Disorder Services?

REC reference: 17/YH/0221

IRAS project ID: 217668

Thank you for your letter of 17 August 2017, responding to the Committee's request for further information on the above research and submitting revised documentation.
The further information has been considered on behalf of the Committee by the Chair and Lead reviewer.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three

months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact hra.studyregistration@nhs.net outlining the reasons for your request.

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval
A Research Ethics Committee established by the Health Research Authority

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Appendix L-Email Correspondence and HRA Approval Letter

Email From: APPROVAL, hra (Health Research Authority)

Sent: 4 September 2017

Subject: IRAS 217668. Outcome of Application for HRA Approval

Dear Miss Webb

RE: IRAS 217668. How are Endings Experienced in Community PD Services? Outcome of Application for HRA Approval.

Please find attached a letter informing you of the outcome of your application for HRA Approval.

Please read the attached documents with care.

You may now commence your study at those participating NHS organisations in England that have confirmed their capacity and capability to undertake their role in your study (where applicable). Detail on what form this confirmation should take, including when it may be assumed, is given in Appendix B of the HRA Approval letter.

If you have any queries please do not hesitate to contact me.

Kind regards

Michael Pate
Assessor

Michael Pate
Assessor

Health Research Authority

3rd Floor – Barlow House | 4 Minshull Street | MANCHESTER | M1 3DZ
T. 0207 104 8197
E. michael.pate@nhs.net
W. www.hra.nhs.uk

……..

Letter of HRA Approval

Health Research Authority

Email: hra.approval@nhs.net

Miss Kimberley Webb
College of Social Science
Ground Floor, Bridge House
University of Lincoln, Brayford Pool, Lincoln
LN6 7TS

04 September 2017

Dear Miss Webb

Study Title: How are Endings Experienced By Service Users in Community Personality Disorder Services?

IRAS project ID:	**217668**
REC reference:	**17/YH/0221**
Sponsor	**University of Lincoln**

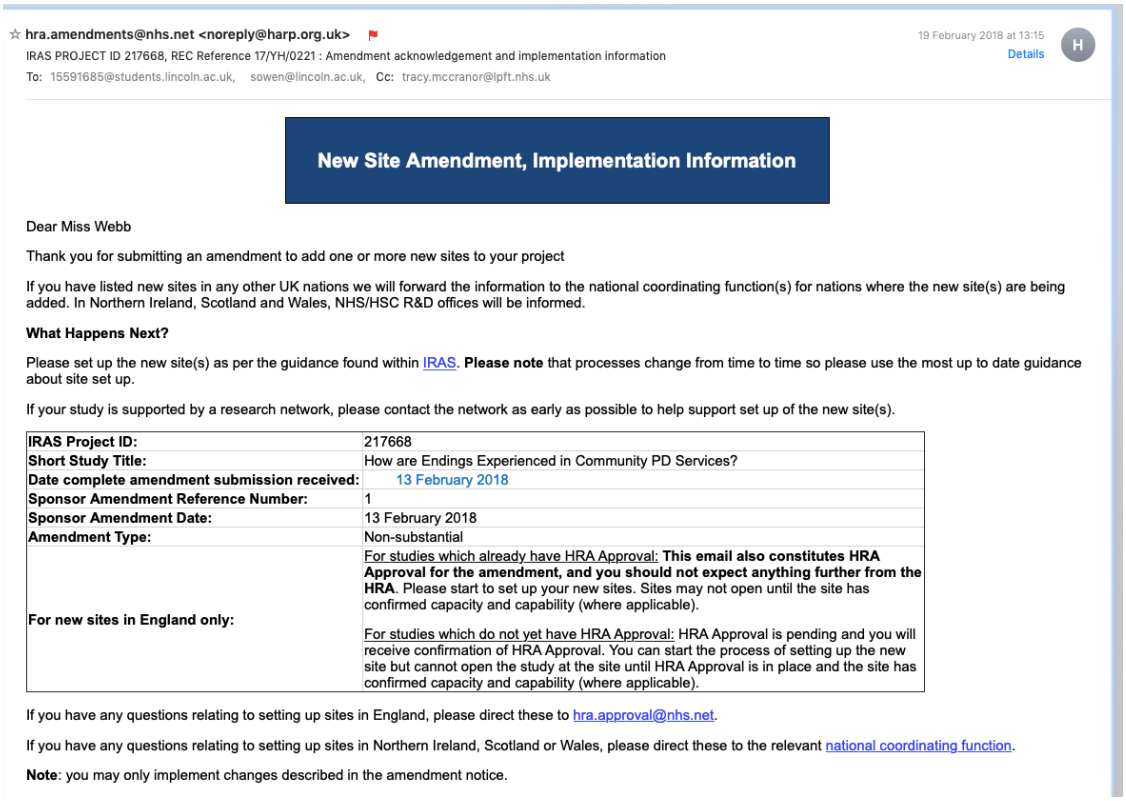
I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

The remaining eight pages from the letter have been omitted.

Appendix M- Substantial Amendment 1 Approval



☆ **hra.amendments@nhs.net <noreply@harp.org.uk>**

19 February 2018 at 13:15
Details

IRAS PROJECT ID 217668, REC Reference 17/YH/0221 : Amendment acknowledgement and implementation information

To: 15591685@students.lincoln.ac.uk, sowen@lincoln.ac.uk, Cc: tracy.mccranor@lpft.nhs.uk

New Site Amendment, Implementation Information

Dear Miss Webb

Thank you for submitting an amendment to add one or more new sites to your project

If you have listed new sites in any other UK nations we will forward the information to the national coordinating function(s) for nations where the new site(s) are being added. In Northern Ireland, Scotland and Wales, NHS/HSC R&D offices will be informed.

What Happens Next?

Please set up the new site(s) as per the guidance found within IRAS. **Please note** that processes change from time to time so please use the most up to date guidance about site set up.

If your study is supported by a research network, please contact the network as early as possible to help support set up of the new site(s).

IRAS Project ID:	217668
Short Study Title:	How are Endings Experienced in Community PD Services?
Date complete amendment submission received:	13 February 2018
Sponsor Amendment Reference Number:	1
Sponsor Amendment Date:	13 February 2018
Amendment Type:	Non-substantial
For new sites in England only:	For studies which already have HRA Approval: **This email also constitutes HRA Approval for the amendment, and you should not expect anything further from the HRA**. Please start to set up your new sites. Sites may not open until the site has confirmed capacity and capability (where applicable). For studies which do not yet have HRA Approval: HRA Approval is pending and you will receive confirmation of HRA Approval. You can start the process of setting up the new site but cannot open the study at the site until HRA Approval is in place and the site has confirmed capacity and capability (where applicable).

If you have any questions relating to setting up sites in England, please direct these to hra.approval@nhs.net.

If you have any questions relating to setting up sites in Northern Ireland, Scotland or Wales, please direct these to the relevant national coordinating function.

Note: you may only implement changes described in the amendment notice.

Appendix N: Substantial Amendment 2

LEEDSWEST, NRESCommittee.YorkandHumber- (HEALTH RESEARCH AUTHORITY)

1 February 2018 at 12:06

Details

17-YH-0221 IRAS 217668. Amendment confirmation of REC Validation, categorisation and implementation information

To: Kimberley Webb (15591685), Cc: Sara Owen, McCranor Tracy (LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST)

Amendment Confirmation of REC Validation, Categorisation and Implementation Information

Dear Kimberley

Thank you for submitting an amendment to your project. Please find attached a copy of the REC validation letter for the submitted amendment.

If you have participating NHS/HSC organisations in any other UK nations we will forward the information to the relevant national coordinating function(s).

Please note that you may only implement changes described in the amendment notice.

What Happens Next?

When available, please forward any other regulatory approvals that are expected for this amendment to hra.amendments@nhs.net. However, you do not need to forward the REC favourable opinion as we will be able to access this through our systems.

Information Specific to Participating NHS Organisations in England

1. You should now share your notice of amendment and, if applicable, amended documents, together with this email, with all participating NHS organisations in England. In doing so, you should include the NHS R&D Office, LCRN (where applicable) as well as the local research team. A template email to notify participating NHS organisations in England is provided on the HRA website.
2. The participating NHS organisations in England should prepare to implement this amendment.
3. Your amendment will be reviewed by the REC, as per the attached letter. In parallel to this, an assessment against HRA standards will take place.
4. Once the REC Favourable Opinion is issued, any other regulatory approvals are in place and the HRA assessment has been successfully completed, you will receive an email confirming that your amendment has HRA Approval.
5. You may implement your amendment at all participating NHS organisations in England 35 calendar days from the day on which you provide the organisations with this email and your amended documents (or as soon as the participating NHS organisation confirm that you may implement, if sooner), so long as you have HRA Approval for your amendment by this date. **NHS organisations do not have to confirm they are happy with the amendment.** If HRA Approval is issued subsequent to this date, you may implement following HRA Approval.
6. You may not implement the amendment at any participating NHS organisations in England that requests additional time to assess, until it confirms that it has concluded its assessment.
7. You may not implement at any participating NHS organisation in England that declines to implement the amendment.

IRAS Project ID:	217668
Short Study Title:	How are Endings Experienced in Community PD Services?
Date complete amendment submission received:	31 January 2018
Amendment No./ Sponsor Ref:	SA2
Amendment Date:	31 January 2018
Amendment Type:	Substantial
Outcome of HRA Assessment	**HRA Approval for the amendment is pending.** The HRA will separately confirm HRA Approval for the amendment by email.
Implementation date in NHS organisations in England	35 days from date amendment information together with this email, is supplied to participating organisations (provided HRA Approval for the amendment is in place and conditions above are met)

Appendix O: Non-Substantial Amendment Confirmation

☆ **hra.amendments@nhs.net <noreply@harp.org.uk>**

19 February 2018 at 13:15
Details

IRAS PROJECT ID 217668, REC Reference 17/YH/0221 : Amendment acknowledgement and implementation information

To: 15591685@students.lincoln.ac.uk, sowen@lincoln.ac.uk, Cc: tracy.mccranor@lpft.nhs.uk

New Site Amendment, Implementation Information

Dear Miss Webb

Thank you for submitting an amendment to add one or more new sites to your project

If you have listed new sites in any other UK nations we will forward the information to the national coordinating function(s) for nations where the new site(s) are being added. In Northern Ireland, Scotland and Wales, NHS/HSC R&D offices will be informed.

What Happens Next?

Please set up the new site(s) as per the guidance found within IRAS. **Please note** that processes change from time to time so please use the most up to date guidance about site set up.

If your study is supported by a research network, please contact the network as early as possible to help support set up of the new site(s).

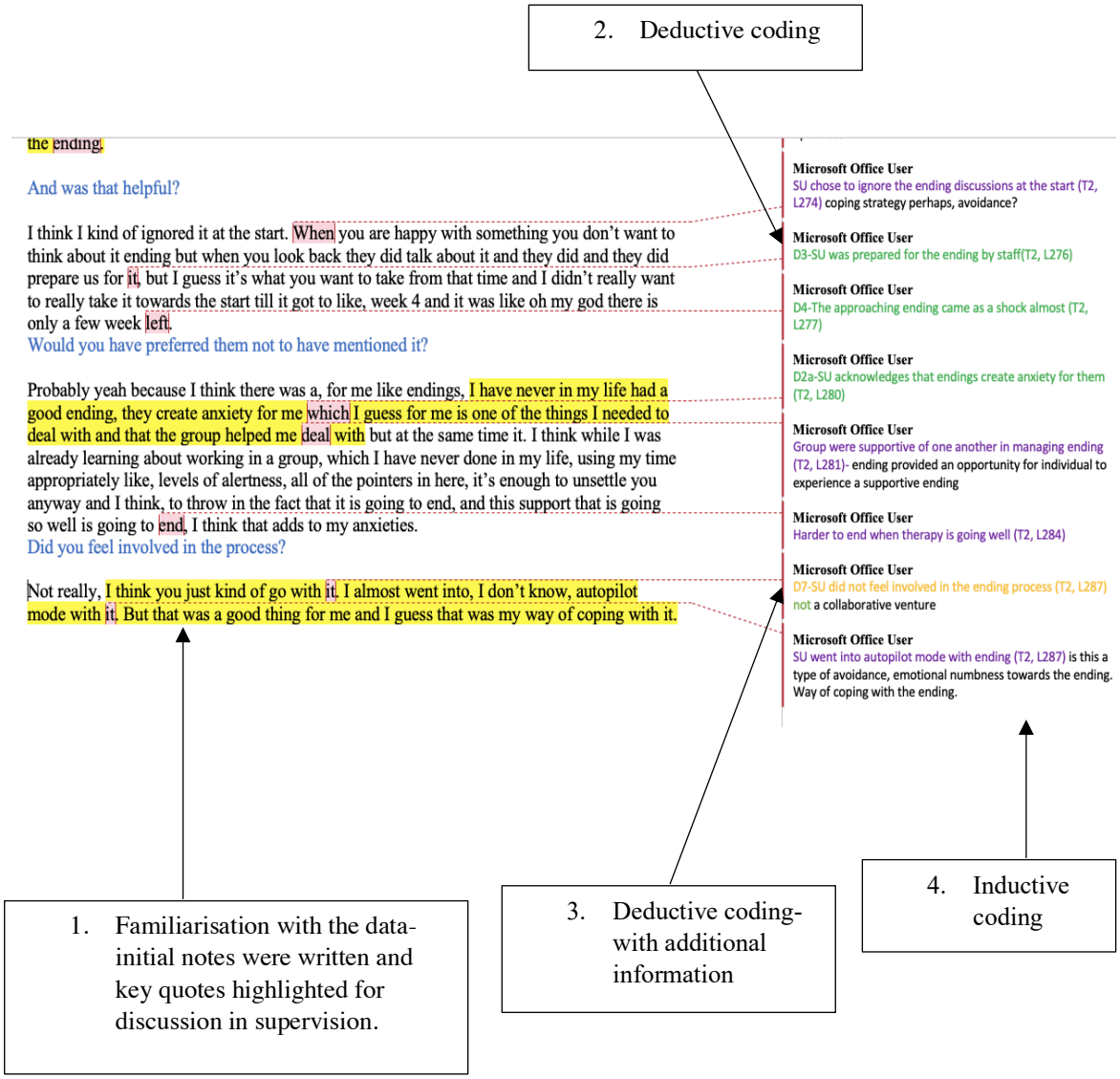
IRAS Project ID:	217668
Short Study Title:	How are Endings Experienced in Community PD Services?
Date complete amendment submission received:	13 February 2018
Sponsor Amendment Reference Number:	1
Sponsor Amendment Date:	13 February 2018
Amendment Type:	Non-substantial
For new sites in England only:	For studies which already have HRA Approval: **This email also constitutes HRA Approval for the amendment, and you should not expect anything further from the HRA**. Please start to set up your new sites. Sites may not open until the site has confirmed capacity and capability (where applicable). For studies which do not yet have HRA Approval: HRA Approval is pending and you will receive confirmation of HRA Approval. You can start the process of setting up the new site but cannot open the study at the site until HRA Approval is in place and the site has confirmed capacity and capability (where applicable).

If you have any questions relating to setting up sites in England, please direct these to hra.approval@nhs.net.

If you have any questions relating to setting up sites in Northern Ireland, Scotland or Wales, please direct these to the relevant national coordinating function.

Note: you may only implement changes described in the amendment notice.

Appendix P- Annotated Transcript

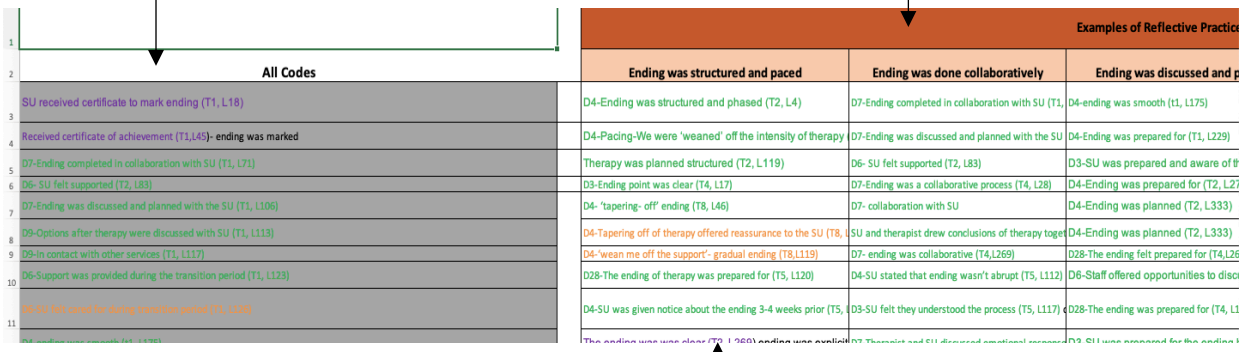


Appendix Q: Excel Spreadsheet

Example 1

1. All codes inputted into excel spreadsheet

3. Initial sub-themes and themes emerge

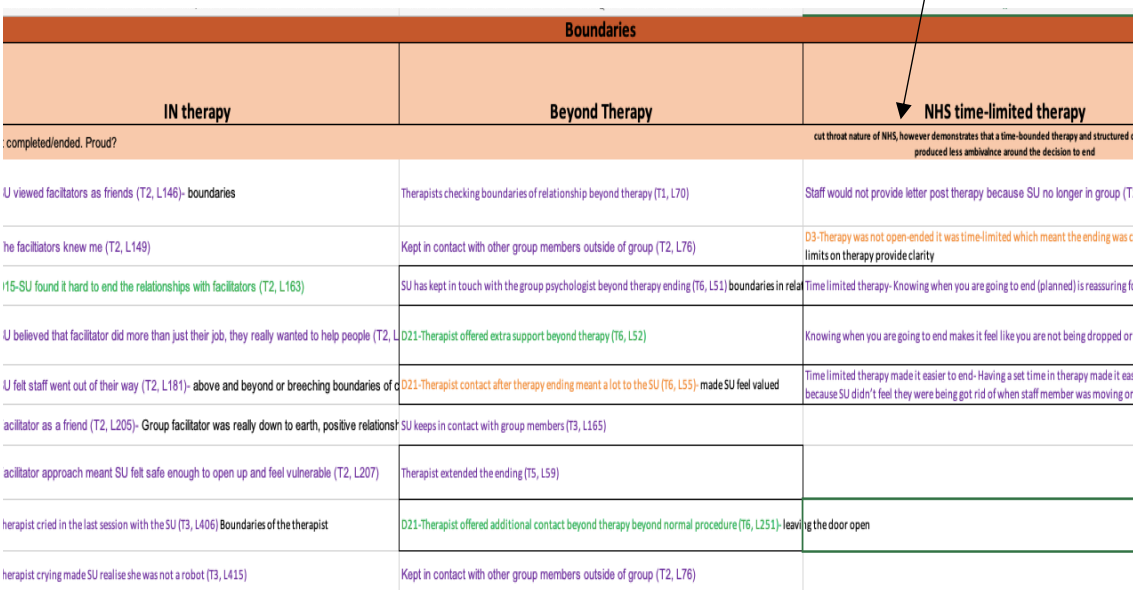


All Codes	Ending was structured and paced	Ending was done collaboratively	Ending was discussed and p
SU received certificate to mark ending (T1, L18)	D4-Ending was structured and phased (T2, L4)	D7-Ending completed in collaboration with SU (T1,	D4-ending was smooth (t1, L175)
Received certificate of achievement (T1,L45)- ending was marked	D4-Pacing-We were 'weaned' off the intensity of therapy (	D7-Ending was discussed and planned with the SU	D4-Ending was prepared for (T1, L229)
D7-Ending completed in collaboration with SU (T1, L71)	Therapy was planned structured (T2, L119)	D6- SU felt supported (T2, L83)	D3-SU was prepared and aware of t
D6- SU felt supported (T2, L83)	D3-Ending point was clear (T4, L17)	D7-Ending was a collaborative process (T4, L28)	D4-Ending was prepared for (T2, L27
D7-Ending was discussed and planned with the SU (T1, L106)	D4- 'tapering- off' ending (T8, L46)	D7- collaboration with SU	D4-Ending was planned (T2, L333)
D9-Options after therapy were discussed with SU (T1, L113)	D4-Tapering off of therapy offered reassurance to the SU (T8, L	SU and therapist drew conclusions of therapy toget	D4-Ending was planned (T2, L333)
D9-In contact with other services (T1, L117)	D4-'wean me off the support'- gradual ending (T8,L119)	D7- ending was collaborative (T4,L269)	D28-The ending felt prepared for (T4,L26
D6-Support was provided during the transition period (T3, L123)	D28-The ending of therapy was prepared for (T5, L120)	D4-SU stated that ending wasn't abrupt (T5, L112)	D6-Staff offered opportunities to disc
D6-SU felt cared for during transition period (T1, L103)	D4-SU was given notice about the ending 3-4 weeks prior (T5, L	D3-SU felt they understood the process (T5, L117) (	D28-The ending was prepared for (T4, L1
D4-ending was smooth (t1, L175)	The ending was was clear (T3, L269) ending was explicit	D7-Therapist and SU discussed emotional responses	D3-SU was prepared for the ending

2. Codes are organised and linked together into categories or related codes

Example 2

4. Adding a description to the sub-themes aided the analysis



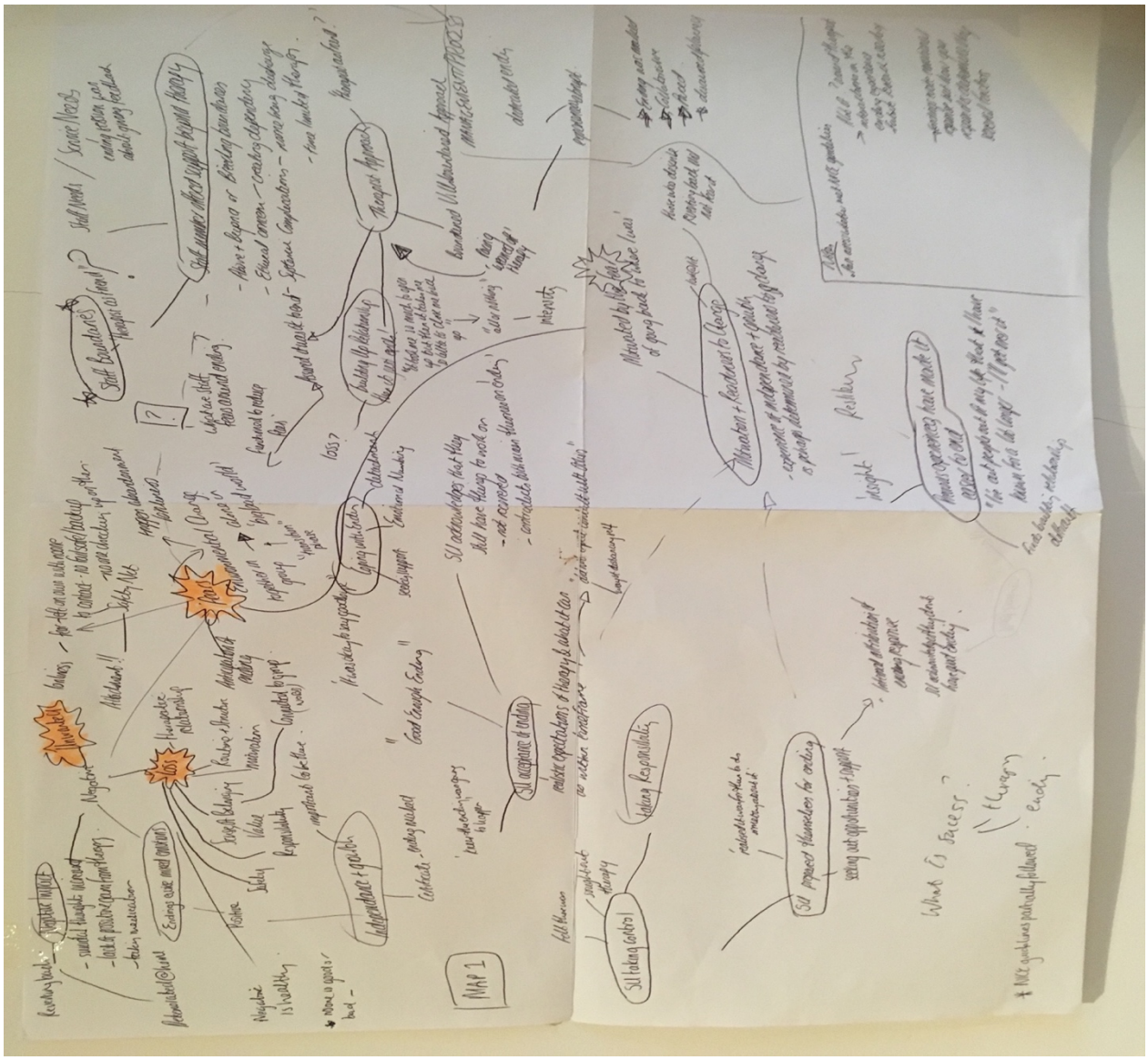
Boundaries		
IN therapy	Beyond Therapy	NHS time-limited therapy
completed/ended. Proud?		cut throat nature of NHS, however demonstrates that a time-bounded therapy and structured produced less ambivalnce around the decision to end
U viewed facilitators as friends (T2, L146)- boundaries	Therapists checking boundaries of relationship beyond therapy (T1, L70)	Staff would not provide letter post therapy because SU no longer in group (T
he facilitiators knew me (T2, L149)	Kept in contact with other group members outside of group (T2, L76)	D3-Therapy was not open-ended it was time-limited which meant the ending was c limits on therapy provide clarity
15-SU found it hard to end the relationships with facilitators (T2, L163)	SU has kept in touch with the group psychologist beyond therapy ending (T6, L51) boundaries in relat	Time limited therapy- Knowing when you are going to end (planned) is reassuring fe
U believed that facilitator did more than just their job, they really wanted to help people (T2, L	D21-Therapist offered extra support beyond therapy (T6, L52)	Knowing when you are going to end makes it feel like you are not being dropped or
U felt staff went out of their way (T2, L181)- above and beyond or breeching boundaries of c	D21-Therapist contact after therapy ending meant a lot to the SU (T6, L55)- made SU feel valued	Time limited therapy made it easier to end- Having a set time in therapy made it eas because SU didn't feel they were being got rid of when staff member was moving or
acilitator as a friend (T2, L205)- Group facilitator was really down to earth, positive relationsh	SU keeps in contact with group members (T3, L165)	
acilitator approach meant SU felt safe enough to open up and feel vulnerable (T2, L207)	Therapist extended the ending (T5, L59)	
herapist cried in the last session with the SU (T3, L406) Boundaries of the therapist	D21-Therapist offered additional contact beyond therapy beyond normal procedure (T6, L251)- leaving the door open	
herapist crying made SU realise she was not a robot (T3, L415)	Kept in contact with other group members outside of group (T2, L76)	

Appendix R: Excel Spreadsheet- Reviewing Themes

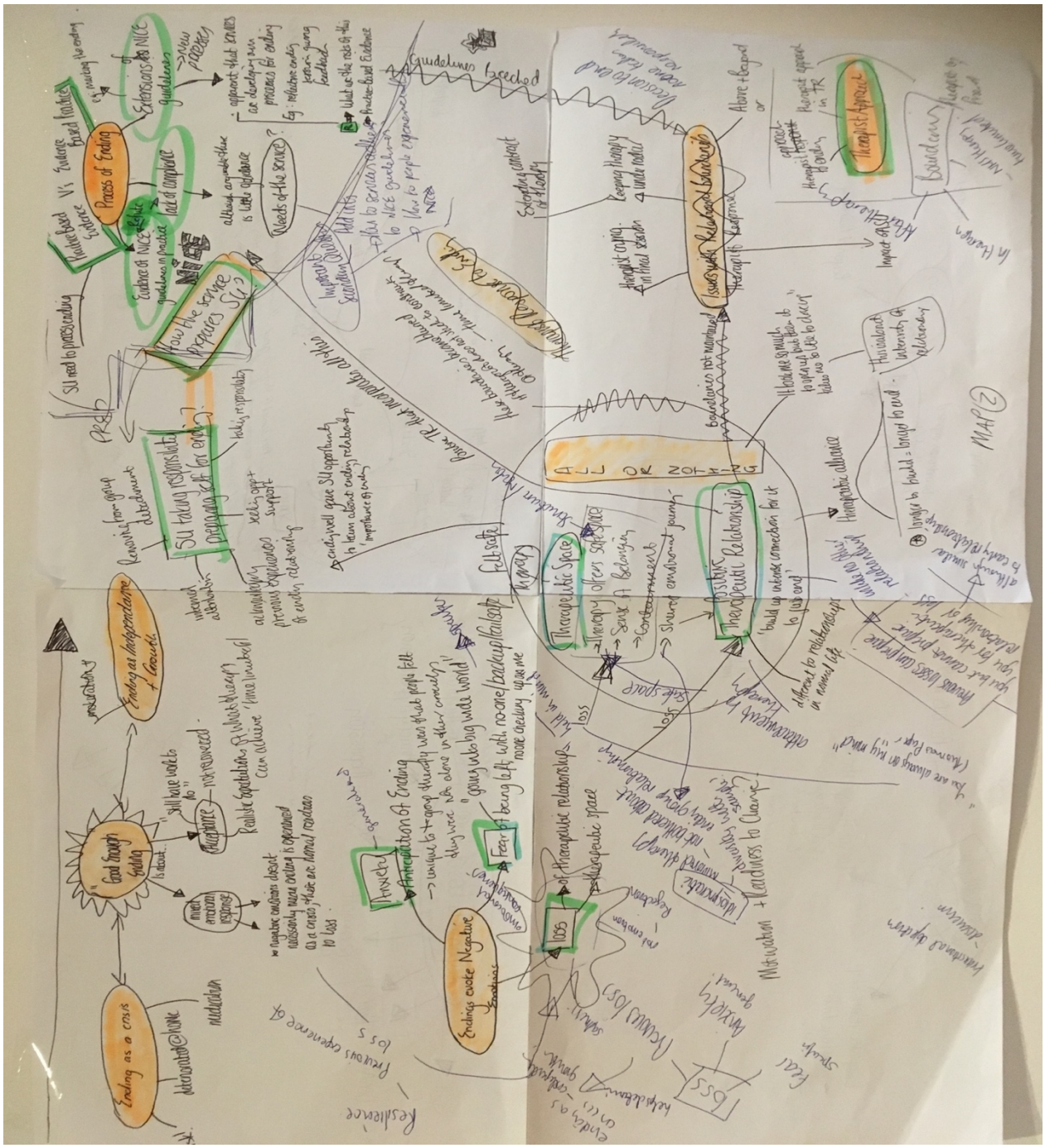
Theme	Description	Sub-Theme	Description	Supportive Quotations
Reflective vs Reactive Practice	This theme captures the contrasts between SU experiences of endings that where seemingly in reciept of either reflective or reactive practice.	**Reflective Practice**	This sub-theme captures the SU experiences of endings that were in reciept of reflective practice. In summary SU experienced endings as structured and phased, discussed and planned, collaborative and supportive during transitions with other care providers.	I guess we all knew it was going to come to an end so they did slowly wean us off the intensity (t2, l26), I think it was good how it was planned out (t2,l333), I felt I was prepared for it .(t1,L55), No I met her before it had finished and then it continued just after it finished to try and get me in touch with somebody.(t1, L123), You then went onto the step down group after the therapeutic community. (t3, L46) "she was writing a letter to the drs about what I wanted, for the doctor to know my finish discharge notes essentially and then she was calling to follow through with that to say is there anything else you need kind of thing." (t8, L42) "They were very clearly trying to wean me off the support , you know they would say we need to you try and cope without calling us to make it easier for when you do leave."(T8, L119) evidence of self pacing "knowing it was going to end, I thought it would be easier to pull myself back than get frantic and try and absorb as much as I could and as quick as I could. Take a step back and adjust."(t8,L338), "I think I was well prepared, I think we had drawn the conclusions together that I needed from the year long therapy. "(T4,L93) "because the hospital is really big itself, they looked at options outside of the hospital like charities and things that offer support groups or urm.. different things really, you know like, they just hold, like a community centre. " (t6, L17)
		Reactive Practice	This sub-theme captures the experiences of service users of endings that were in reciept of reactive clinical practice. Examples include where the ending process was unclear, abrupt and non-collaborative.	I ended up having two sessions and the ending all in three days (t2,L46) I felt it was a rushed ending (T2, L52)I don't really know I was involved(t1, L279), I don't really know what the process was (T1, L285) "the second time I phoned still couldn't get through so I left a message of his voice mail for him to get in contact with me, and I never got any reply and then I spoke to a lady called ..... who told me that Mr .... he'd left the practice." (T5, L20), ", it was a bit, it was a bit abrupt".(t5, L41), "I didn't know what was going on, it was up in the air kind of thing. "(t5, L61), "You know, been thinking the ending was so sharp, like abruptly"(t5, L92), "all of sudden I got a letter from the mental health team saying I am no longer with them and if I need to be seen it would be through my GP."(t5, 167)
		Emotional impact of the ending process	This sub-theme captures the emotional impact of the ending process experienced by the SU relative to when ending management appeared reflective vs reactive	"Yes it did help, the tapering off period because although it ended in October I feel like I have only just fully finished now (March). " (T8, L46). "It's just none of us were helped to understand the pain and we have all kind of ran away in our own directions from the pain." T2, L360, "It feel good that somebody cared, you know they cared enough to try and find something else for me to do". (t1, L126) "It has just left me a bit bemused. "(t5,L87), "But, you know he did tell me and you know I understood what was going to happen, and that was just, I thought like, oh right, at least he is not going to leave me adrift in the sea, kind of thing, "(t5,L124) "We will see you when you next try to kill yourself. That is not what is said obviously but that is how it makes you feel."(t6, L215) "like they don't care or that you had wasted 12 months because now you're just going back to the life you had before."(t6, L229)
				"I think I would definitely keep the mentioning it part because as much as for me it wasn't something I wanted to hear, I think the way that I am feeling now would have been a lot worse if it wasn't mentioned."(t2,347) "It's like its diluted it

Appendix S: Diagrammatic Maps- Developing and Refining Themes

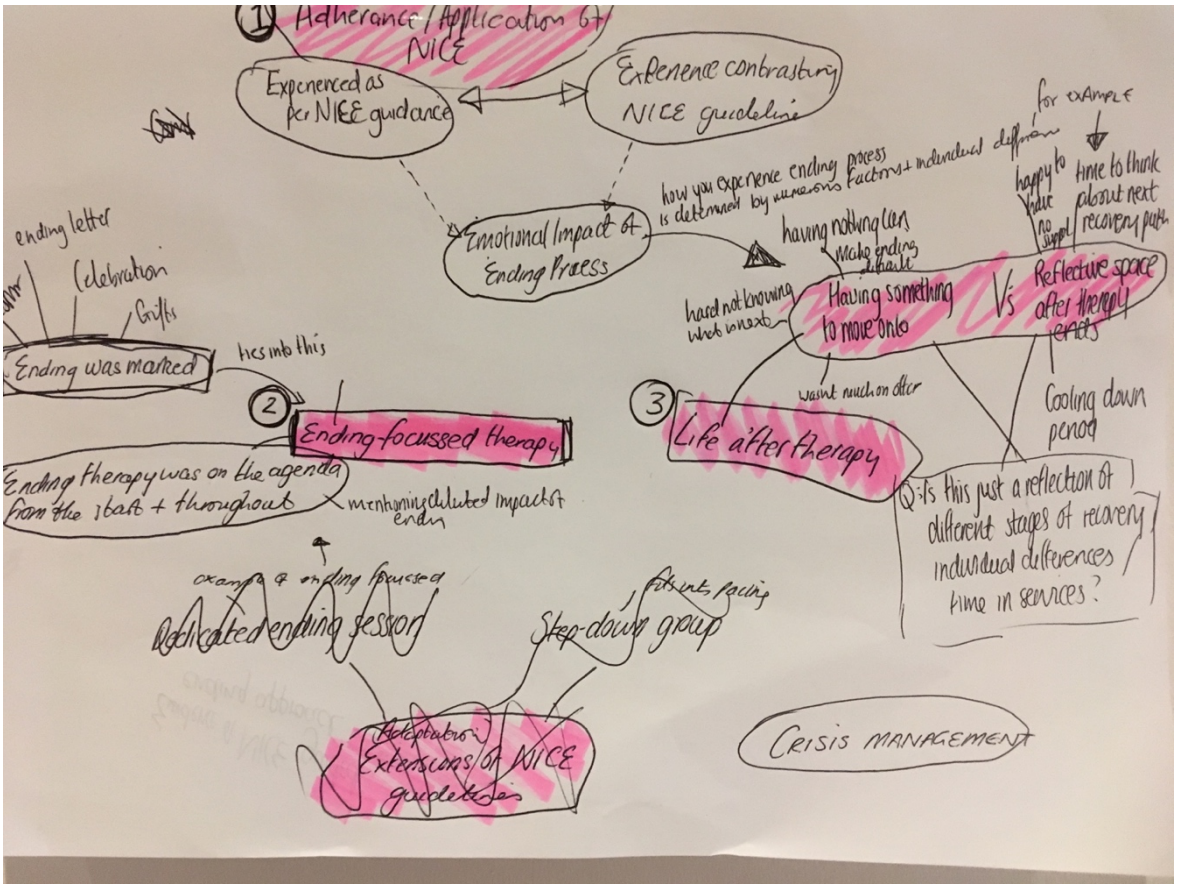
Map 1



Map 2


MAP 2
Process of Ending
Evidence of NICE-style guidelines in practice
Lack of compliance
Extensions to NICE guidelines
Guidelines breached
Above + beyond or
Therapist Approach
Boundaries
Impact of Therapy
Issues with Relational Boundaries
Therapist response
Therapist Approach to Ending
Therapist Response to Ending
Therapist Response to Ending
Therapist Response

Map 3


1
Adherance / Application of NICE
Experienced as per NICE guidance
Experience contrasting NICE guideline
Emotional Impact of Ending Process
how you experience ending process is determined by numerous factors + individual differences
for example
happy to have no support
time to think about next recovery path
having nothing else make ending tolerable
hard not knowing what is next
Having something to move onto
Vs
Reflective space after therapy ends
ending letter
Celebration
Gifts
Ending was marked
ties into this
2
Ending focussed therapy
Ending therapy was on the agenda from the start + throughout
monitoring diluted impact of ending
3
Life after therapy
wasn't much on offer
Cooling down period
Q: Is this just a reflection of different stages of recovery individual differences time in services?
example of ending focussed
Dedicated ending session
Step-down group
Adaptations / Extensions of NICE guidelines
Crisis management

Grounding Clinical Guidelines in Service Users Experiences of Ending

Kimberley Webb, Thomas Schröder, Mark Gresswell
Trent Doctorate in Clinical Psychology,
Universities of Lincoln and Nottingham, UK

Background

Importance of Endings

- Ending are considered an important phase of the therapeutic process[1]
- Endings are particularly relevant for individuals with a Personality Disorder (PD) diagnosis due to the difficulties experienced with real or imagined abandonment[2].

Conceptualisation of Endings

- The theoretical literature concurs that endings are experienced as a 'loss'. Initially ending were considered a point of crisis, however, more recently there has been a shift towards 'ending as transformation' model[3].

Management of Endings in Practice

- Despite the relative importance of endings, the empirical literature informing the management of endings is sparse[4]. In particular, there is a lack of evidence derived from service users' subjective experiences.
- NICE guidelines[5] supporting the management of endings in practice are also are limited and warrant further empirical support.

Aim

- The current study aims to explore service users' subjective experiences of endings from community PD services.
- The researchers hope to contribute to the empirical evidence base and provide further recommendations for the management of endings in clinical practice.

Results

Reflective Vs Reactive Practice

"*It feel good that somebody cared, you know they cared enough to try and find something else for me to do*".

"*I didn't know what was going on, it was up in the air kind of thing.* "

Endings Held in Mind
Explicit from the start, Not a taboo and Marking the end

"They very much make it time bound and so I suppose for the whole time I was doing it, that was on the agenda almost, if you know what I mean."

"*It was always there so it wasn't a surprise* "

What Next?
Filling the Void or A welcomed Break

"You know there is a lot going on and I think if you have got nothing else it would maybe race around in your mind and make you worse. "

"*I felt I was just ready to move on, and put stuff behind me… I wanted a break from therapy"*

Discussion

Reflective Vs Reactive Practice

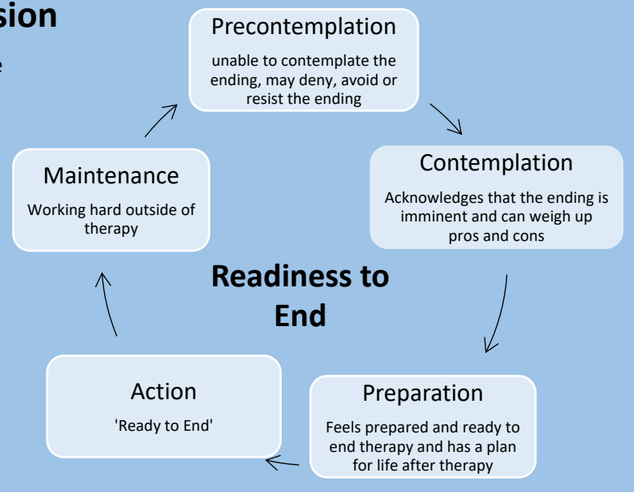
- The findings highlight the importance of adopting a reflective pro-active approach to the management of endings and the positive impact that this had on service users' experiences.
- The contrasts between service users' experiences indicate variation in how ending processes are managed in practice which highlight two salient points; 1) adherence to clinical practice guidelines, and 2) services are adopting their own 'best practices' for ending.

Endings held in Mind

- The repeated mentioning and discussion of the anticipated ending may function to gradually and repeatedly expose an individual to the loss of therapy and reduce the emotional impact of ending.

What Next?

- The differences in service-user's responses towards the anticipated endpoint can be understood relative to an individuals' readiness to end therapy.
- Endings as 'interrupt' model may be particularly helpful for individuals with a PD diagnosis.



Adapted from Prochaska & DiClemente(1983)

Method

- A qualitative approach using semi-structured interviews was used to explore service users' experiences of ending.
- Eight participants were recruited from four NHS community PD services

Eligible Individuals discharged within the last three-months were invited to the service

Participants were provided the opportunity to discuss the project before deciding whether to opt in

Participants were given 24 hours from consent before the telephone interview took place

Interview transcripts were analysed using a mixed deductive-inductive approach (Braun & Clarke, 2006)

An additional 'refutational' stage was incorporated into the analysis as a quality assurance step and aimed to reduce researcher bias.

Recommendations

Clinical

- Take a reflective approach to managing endings
- Make endings explicit from the start
- Put endings on the agenda throughout therapy
- Plan the ending point (whether to mark it)
- Empower the ending (a new chapter)
- Assess an individuals' readiness to end and support transition throughout stages
- Services should also support staff in managing the ending through supervision or additional teaching.

Research

- Further research should aim to develop an understand endings across a range populations, services and different perspectives (service users and staff).

References

[1]Gelso, C., & Woodhouse, H. (2002). The termination of psychotherapy: What research tells us about the process of ending treatment. In G. . Tyron (Ed.), *Counseling based on process research: Applying what we know* (pp. 344–369). Boston: Allyn & Bacon
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[4]Webb, K., Schröder, T. A., & Gresswell, D. M. (2018). Service users' first accounts of experiencing endings from a psychological service or therapy: A systematic review and meta-ethnographic synthesis. *Psychology and Psychotherapy: Theory, Research and Practice*, 1–21.
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[6]Braun, V., & Clarke, V. (2006). Using thematic analysis. *Qualitative Research in Psychology*, *3*,77-101.
[7]Prochaska, J., & DiClemente, C. (1983). Stages and processes of self-change of smoking: Toward and integrative model of change. *Journal of Consulting and Clinical Psychology*, *51*, 390-395